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**"SPIRITUAL ASPECTS OF NURSING: A DESCRIPTIVE  
STUDY OF NURSES' PERCEPTIONS".**

BY

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B.A NURSING (COMMENDATION), RGN

A thesis submitted in fulfilment  
of the requirements of the Council for  
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degree of Doctor of Philosophy.

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" As you ought not to attempt to cure the eyes  
without the head, or the head without the body,  
so neither ought you to attempt to cure the  
body without the soul... for the part can  
never be well unless the whole is well".

(Plato in Sims 1987, p 65)

" Spiritual is what is human to man".

(Frankl in Granstrom 1985, p 41)

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## ABSTRACT

This descriptive, exploratory study examines nurses' perceptions of spiritual care.

Having reviewed the literature it became apparent that the spiritual dimension can influence health, well-being and quality of life. Moreover, the nursing literature considers spiritual care part of the nurse's role, however, guidelines for its practice are absent. Research on spiritual care, particularly of British origin, is very much in its infancy and nothing is known about how British nurses perceive their role in this.

A conceptual framework for giving spiritual care using the Nursing Process is, therefore, offered by the researcher, although this still requires testing.

The study, believed to be the first of its kind in Britain, ascertained how nurses, working in care of the elderly hospitals in Scotland, perceived spiritual need and spiritual care and professed to have given this care in practice. This was achieved by distributing a purpose designed postal questionnaire to the population of nurses (n=1170) in 1991. A response rate of 67.8% (n=793) was achieved, 58.5% (n=685) of questionnaires being usable.

In addition, factors which appeared to influence the spiritual care nurses gave were identified. Initially clues to possible factors were obtained by conducting a certain statistical

analysis using nurses' responses in the questionnaires. Further exploration of factors influencing spiritual care took place through interviewing a sample (n=12) of nurses.

Findings revealed that nurses in the larger sample (n=685) seemed able to identify patients' spiritual needs and evaluate the care given, mainly through using non-verbal/indirect verbal cues displayed by patients. Nurses were, however, less willing/able to personally respond to these needs. Whereas for some nurses their reluctance to respond to patients' spiritual needs may have been due to their disclaim of responsibility for spiritual care, for others it seemed to be due to feelings of inadequacy.

Charge nurses claiming religious affiliation and working on varied wards in certain geographical locations were most likely to have claimed to have identified patients' spiritual needs. However, it seemed, from the limited sample interviewed, that personal characteristics of the nurse were perhaps more important than the forementioned factors in determining the spiritual care given.

Furthermore, factors relating to other professionals, the ward environment and the patient appeared to influence the way in which spiritual care was given to patients.

The limitations of the study are acknowledged and the implications of the findings discussed.

Given the descriptive nature of the study its prescriptive function is limited which highlights the need for further research in this important area of patient care.

## INTRODUCTION

The author's interest in the subject of spiritual care was stimulated following an encounter with a terminally ill patient. Having been asked if she would like a passage read to her from the Bible lying on her locker, the change in this woman's expression was remarkable. Instead of lying sleeping, or staring blankly into space, her eyes widened, she strained to raise her head, smiled and attempted to speak for the first time in several months. Later, just before she died, she expressed how much this, together with prayer, had meant to her. She said "I love you and thank you". She had a spiritual need which she required to have met.

This profound and moving experience suggested to the author that the spiritual dimension could have a considerable influence on a patient's quality of life while in hospital. In this instance, however, trained staff appeared to allow other tasks, such as tidying the linen cupboard, to assume priority over spiritual care.

It was with the desire to discover more, from the literature, about the relationship between the spiritual dimension, health and quality of life that an under-graduate research proposal was designed (Waugh 1986). The proposal formed the basis for this study which aims to: 1) ascertain how a sample of nurses, working in Scotland, perceive spiritual need and spiritual care and profess to give it in practice 2) identify factors appearing to influence spiritual care.

In Chapter 1 the relevant literature on spiritual care is reviewed. First, evidence is presented for the influence of the spiritual dimension on health, well-being and quality of life (Section 1). Second, spiritual care is presented as part of the nurse's role (Sections 2 and 3). However, it is shown that guidelines for its practice are currently lacking and that patients' spiritual needs may not be well attended to (Section 4).

A conceptual framework for giving spiritual care, based on the Nursing Process, is suggested in Chapter 2, but has not yet been tested.

Chapter 3 gives an overview of the study outlining the research questions and the blend of quantitative and qualitative approaches adopted to address them. A more detailed account of the quantitative and qualitative approaches is given in Chapters 4 and 5 respectively and within each relevant findings are presented and discussed.

In the final chapter (Chapter 6) conclusions are drawn from the findings, their implications are discussed and suggestions for practice and further research are proposed.

## ETHICAL CONSIDERATIONS

Two main ethical questions arose in connection with conducting the study as outlined below.

1 Was it right that a research study should be initiated and guided by the personal stance of the researcher?

As a Christian, my personal spirituality both initiated the study and inspired the analysis. However, it is unlikely that the study itself would have proceeded if the literature review had not supported spiritual care as part of the nurse's role. Furthermore, every research question is born out of a particular hunch an individual has. Consequently no research can be totally value free.

As described more fully later in the text, measures were employed to minimise the effects of researcher bias and on occasions it was suggested that the researcher might have over-compensated for her beliefs.

2 Given the personal nature of spirituality, was it right to seek collaboration from nurses who may not have wished to participate in the study?

To do so was considered justified given that nurses were invited to participate and their informed voluntary consent obtained, details of which are given later in the text.

## ASSUMPTIONS AND EXPLANATION OF ABBREVIATIONS AND TERMS USED

### ASSUMPTIONS

For the purpose of this study the following assumptions are made:

- 1 the spiritual dimension is an innate element of every human being, regardless of the presence or absence of religious beliefs and practices. As such, all human beings have spiritual needs
- 2 an optimum state of health, well-being and quality of life is valued by and striven for by all human beings.

### ABBREVIATIONS

AACN	-	American Association of Colleges of Nursing
ICN	-	International Council of Nurses
NHS	-	National Health Service
NBS	-	National Board for Nursing, Midwifery and Health Visiting for Scotland
NANDA-		North American Nursing Diagnosis Association
RGN	-	Registered General Nurse
SPSS	-	Statistical Package for the Social Sciences
SRN	-	State Registered Nurse
UKCC	-	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

### TERMS

- 1 Researcher and author refer to the writer of the thesis.
- 2 Man denotes both male and female members of humankind.
- 3 The female gender is used when referring to the nurse.
- 4 Statements relating to nurses' perceptions of spiritual need and spiritual care and how they gave this care refer to their reports about each.
- 5 The terms "tendency to" and "influence" are used in the discussion of the study results, in a non-statistical sense.
- 6 Quotations from Scripture are taken from the Good News Bible.

### OPERATIONAL DEFINITIONS OF TERMS

Clergy	-	the recognised spiritual representative of any religious denomination e.g minister, rabbi.
Conservatism	-	a strong religious conviction of a fundamentalist nature.
Full-time	-	any nurse working 30 hours or more per week.
General hospital	-	any hospital containing a care of the elderly ward and one or more of the following as classified by Chaplin (1989): "general/mixed acute/infectious diseases/ chest/medicine/surgery/paediatric/orthopaedic /ENT/obstetric/maternity".
Geriatric hospital	-	any hospital containing one or more of the following as classified by Chaplin (1989): "geriatric/long stay/assessment/continuing care/rehabilitation".
God	-	higher power as defined by the individual.
Indirect verbal communication	-	conveyance of a message through the emphasis placed on certain words and the tone of voice
Non-psychiatric care of the elderly ward	-	any care of the elderly ward classified as such by the nurse managers of the hospitals approached but excluding those classified by Chaplin (1989) as: "psychiatry/mental illness/mental handicap/ psycho-geriatric".
Non-varied	-	chronic geriatric ward only e.g long term care or acute geriatric ward only e.g geriatric medicine.
Religious affiliation	-	label adopted by an individual to signify their belief system.
Spiritual care	-	making arrangements for the provision for patients' spiritual needs.
Spiritual dimension	-	that element within man from which originates: meaning, purpose and fulfilment in life; a will to live; belief and faith in self, others and God and which is essential to the attainment of an optimum state of health, well-being or quality of life.
Spiritual distress	-	the state resulting when an individual is deprived of having their spiritual needs fulfilled.



- |                         |   |  |
|-------------------------|---|--|
| Spiritual<br>need       | - | a lack of any or all of the following which are required to produce spiritual well-being: meaning, purpose and fulfilment in life; the will to live; belief and faith in self, others and God. |
| Spiritual<br>well-being | - | the overall state of spiritual health which is evidenced by the presence of: meaning, purpose and fulfilment in life; the will to live; belief and faith in self, others and God.              |
| Varied ward             | - | combination of chronic and acute care e.g long term care and geriatric medicine.   |

## CHAPTER 1

### A REVIEW OF THE LITERATURE

## INTRODUCTION

In this chapter the literature relevant to spiritual care in nursing is reviewed in four sections as outlined below.

Section 1: The influence of the spiritual dimension on health, well-being and quality of life.

Section 2: Changing philosophies of health care: an historical overview.

Section 3: Spiritual care: should it be part of the nurse's role?

Section 4: Spiritual care: is it practised by nurses?

### SECTION 1 THE INFLUENCE OF THE SPIRITUAL DIMENSION ON HEALTH, WELL-BEING AND QUALITY OF LIFE

It is the purpose of this section to describe and define the main concepts used throughout the text e.g the "spiritual dimension" and "spiritual need". It is then illustrated how vital these concepts are to the attainment of an optimum state of health, well-being and quality of life which are goals generally striven for by all human beings. The experiences of illness and

hospitalisation are then presented as potential crises which can result in spiritual distress thereby preventing or diminishing the individual's ability to achieve these supreme goals.

1 The inseparability of the concepts of health, well-being and quality of life

First, it is necessary to look at definitions of health, well-being and quality of life and to illustrate that all three terms are inseparably linked.

Quality of life has been defined by Dalkey and Rourke (in Ferrans and Powers 1985, p 15-16) as:-

"... a person's sense of well-being, his satisfaction or dissatisfaction with life, or his happiness or unhappiness."

The World Health Organisation (WHO) (in Kratz 1979, p 22) defines health as :-

"... a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity." (WHO 1978, ALMA ATA, Geneva)

From the above two definitions, it can be seen that both "quality of life" and "health" can be equated with "well-being", indicating that all three terms are inseparably linked.

Furthermore, quality of life is defined in terms of the individual's satisfaction with life.

Satisfaction has been defined by Campbell et al (in Ferrans and Powers 1985, p 17) as:-

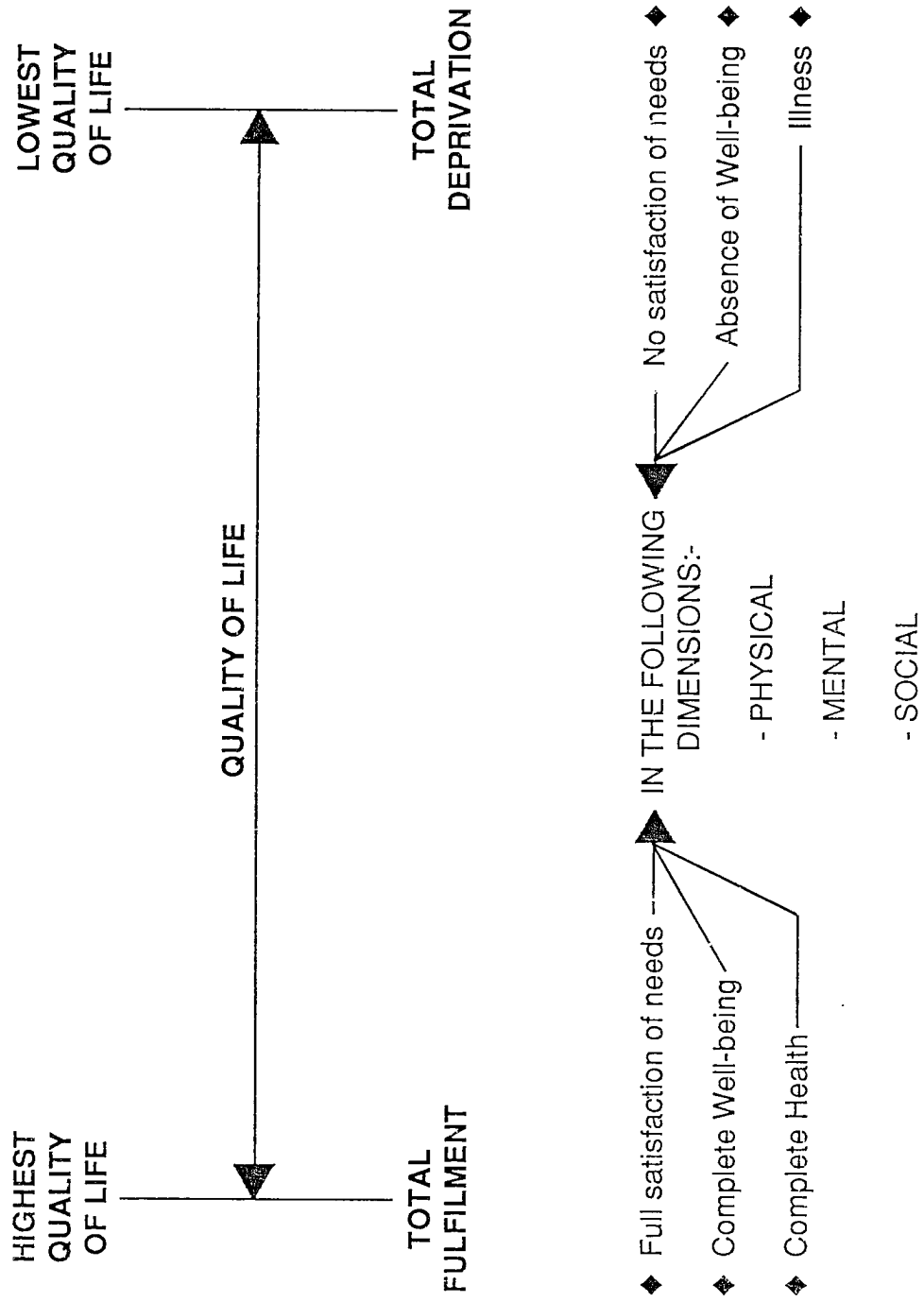
"...the perceived discrepancy between what is aspired to and what is achieved"

and has increasingly been recognised as the most important indicator of quality of life. Quality of life has been described as "the satisfaction of needs" (Ferrans and Powers 1985, p 17). It could be argued, therefore, that the level of quality of life and hence the state of health or well-being (having established the inseparability of these terms) attained by an individual, will be determined by the degree to which their physical, mental and social needs are met with total fulfilment and with total deprivation (if such states actually exist) occupying opposite ends of the quality of life continuum (Figure 1).

Similarly, the literature reviewed frequently acknowledged man as a biopsychosocial being, all three dimensions being inter-related and constantly interacting, change in any one subsequently affecting all others. Brewer (1979) is one such theorist who considers the three dimensions to be directly related to the quality of life experienced in every day living.

Tubesing (1979), however, stresses the importance of realising that man in his wholeness is greater than the sum of his individual parts and should thus be considered in his entirety. This holistic concept of man is by no means a new invention. It

**FIGURE 1: QUALITY OF LIFE CONTINUUM I**



can be traced back to the Indo-European root "kailo" meaning whole or intact. Over several thousand years a number of other words, such as holy, heal, health and whole were derived from it (Hitchens 1988).

Important as it is to view man as a whole biopsychosocial being, this still presents an inadequate and incomplete profile by ignoring a further essential element of his composition - the spiritual dimension. Its importance is aptly stated by De Lourdes (in Thorson and Cook 1980, p139):

"Spiritual well-being supersedes all other values. It is the supreme affirmation of life. To ignore or attempt to separate the need to fulfil the spiritual well-being of a man from attempts to satisfy his physical, material and social needs is to fail to understand the meaning of man."

## 2 Description and definition of the spiritual dimension

Spiritual integrity has been suggested as a basic human need (O'Brien 1982). According to the dictionary (MacDonald 1972) the "spirit" is defined as: the vital principle; the soul; a breath of wind; essence; chief quality; that which gives real meaning. In the literature, the spiritual dimension is described in a multiplicity of ways including the following:

- o the part which strives for meaning and purpose in existence (Dickinson 1975, Henderson 1973, Piepgras 1973, Travelbee 1971, Tillich in Hitchens 1988)

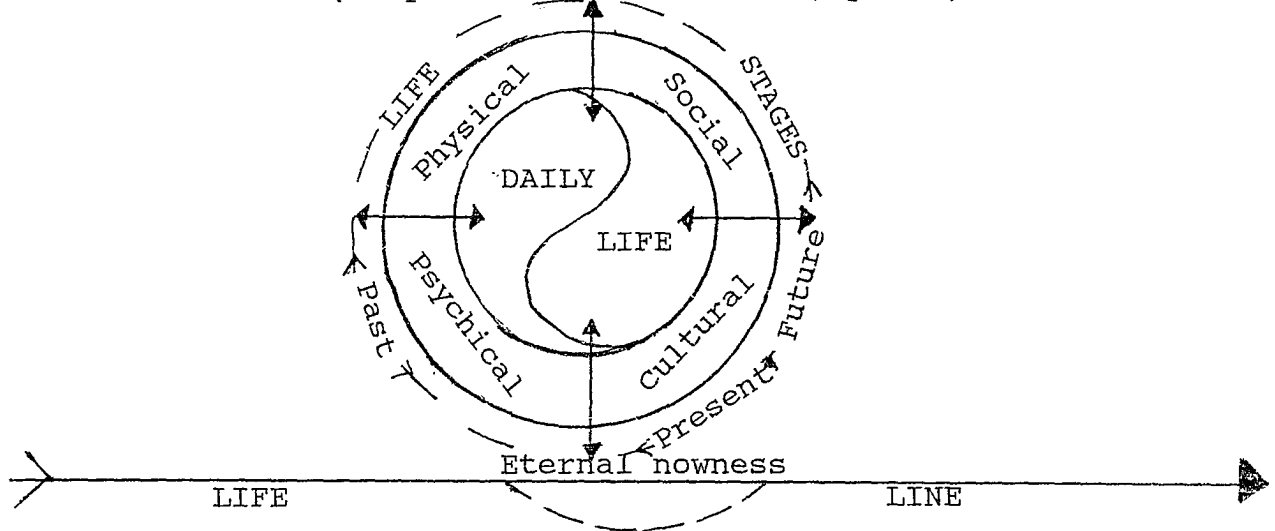
- o the part which strives for transcendence beyond the here and now in search of some higher power or God (however defined by the individual) /something greater than self (Fish and Shelly 1978, Henderson in Henderson and Nite 1978, Martin and Carlson 1988, O'Brien 1982, Stallwood 1975)
- o that which inspires, motivates and hopes, directing the individual toward the values of love, truth, beauty, trust and creativity (Dickinson 1975, O'Brien 1982, Stoll 1979, Travelbee 1971).

From the above descriptions, the spiritual dimension would appear to be a very complex phenomenon. It has been regarded as the central "artery" which permeates, energises and enlivens all of the other dimensions of man (Brewer 1979) and around which all values, thoughts, decisions, behaviours, experiences and ultimate concerns are centred. As such it has been described as the mainstream of life (Dickinson 1975, Stoll 1979, Yura and Walsh 1982) and it has been suggested that without spiritual well-being these other dimensions of man can never function or be developed to their fullest capacity and hence the highest quality of life is unattainable. Brewer (1979) is but one author who depicts the spiritual dimension in a model (Figure 2).



FIGURE 2

MODEL OF SPIRITUAL WELL-BEING  
(adapted from Brewer 1979, p 104)



Brewer recognises four aspects of man, all of which are involved in his day to day living and contribute to the quality of life experienced. These are the:-

- 1) psychical - or "I - me" relationship. This is the highest form of consciousness known, where there exists an awareness of the self through which all things are experienced
- 2) physical - or "I - it", "I - my body", relationship. This involves the individual's relationship with the environment.
- 3) social - or "I - you" "I - them". This refers to the individual's relationship with other fellow human beings, whether as individuals or groups
- 4) cultural - the attitudes, norms, expectations, values and beliefs (in this study the "cultural" is referred to under the "social").

The interaction of these aspects in daily life is dynamic and constantly changing (as indicated by the "2" in the middle circle), all aspects influencing the various life stages, ie. past, present and future (outer dotted circle), as viewed at any one point on the "Life Line" (x - axis on diagram).

However, the point to note is the way in which the spiritual dimension (indicated by ↑) pervades all other dimensions and life stages, allowing for transcendence beyond the ordinary to the extra-ordinary and mystical, thus adding a new dimension and quality to daily living.

From the definitions and descriptions of the spiritual dimension given above it would appear that it is a dual concept consisting of both vertical and horizontal elements as follows.

#### Vertical element

The vertical element could be considered to encompass the transcendental i.e the individual's relationship with God. Although religion with its respective rituals and customs may be one vehicle through which some people experience this relationship, it should not be assumed that the practice of religion by an individual indicates the existence of this relationship. Similarly, the absence of religious practice does not negate it.

For others, such as humanists, the transcendent need not take the form of relationship with/awareness of God but rather may constitute the individual's value system which forms the focus of their life. As Stoll states (in Rinear and Buys 1985, p 867):

"...man is incurably religious...what varies among men is what they are religious about. Whatever a person thinks to be the highest value in life can be regarded as his god, the focus and purpose of his time and life."

### Horizontal element

The horizontal element could be thought of as an outworking of the vertical in the individual's life-style and relationships with self, others and environment.

In summary, the spiritual dimension is a universal aspect of the human being which extends beyond the narrow bounds of religion, stimulating the individual to transcend the realms of the material, psychosocial and ordinariness of every day life, in search of ultimate meaning, purpose and fulfilment in their existence (Kiening 1978, Zentner et al 1979).

The definition which probably best captures and summarises the spiritual dimension is that of Renetzky (1979) who defines it in terms of its three component parts namely:

- 1) the "power within man" giving "meaning, purpose and fulfilment" (MPF) to life, suffering and death
- 2) the individual's "will to live"
- 3) the individual's belief and faith in himself, others and a "power beyond self" or God.

Given the elements in Renetzky's definition, together with the fact that the spiritual dimension supersedes all other dimensions, for the purpose of this study it can be defined as:

"that element within man, from which originates: meaning, purpose and fulfilment in life; a will to live; belief and faith in self, others and God, and which is essential to the attainment of an optimum state of well-being, health or quality of life".

Having described and defined the spiritual dimension, attention now focuses on spiritual need.

### 3 Description and definition of spiritual need

Spiritual need has been defined in a number of ways by different authors. According to Stallwood and Stoll (in Stoll 1983, p15) it is:

"...any factor necessary to establish and/or maintain a person's dynamic personal relationship with God (as defined by that individual) and out of that relationship to experience forgiveness, love, hope, trust and meaning and purpose in life".

Central to the above definition is the individual's relationship with God (as defined by that individual) out of which is experienced:

- o meaning and purpose in life
- o hope
- o trust and faith in someone outwith self
- o love - unconditional from self, others and God

- o forgiveness - from self, others and God.

Spiritual needs included in the study by Highfield and Cason (1983) were based on Clinebell's "religious-existential framework" and included the need:

- o for meaning and purpose
- o to receive love
- o to give love
- o for hope and creativity.

The authors also contend that the above needs are met through the individual's relationship with God, although interpretation of this is left to the reader.

In a similar vein Fish and Shelly (1978) define spiritual need as the need for:

- o meaning and purpose
- o love and relatedness
- o forgiveness.

Although they acknowledge that these needs can be met in part from other sources, they contest that they can only be fully met through a dynamic, personal relationship with God.

Common to all these definitions of spiritual need is the vertical element of spirituality i.e the individual's relationship with/awareness of God which works out in the horizontal i.e in

relationships with self, others and the environment enabling the individual to experience creativity, love, forgiveness, relatedness, trust, faith and to find hope, meaning and purpose in their existence.

These various spiritual needs can be placed under the umbrella of the spiritual dimension definition as illustrated in Figure 3.

Having identified the various facets of spiritual need from definitions given in the literature, it was considered necessary to develop an operational definition of the term for the purpose of this study.

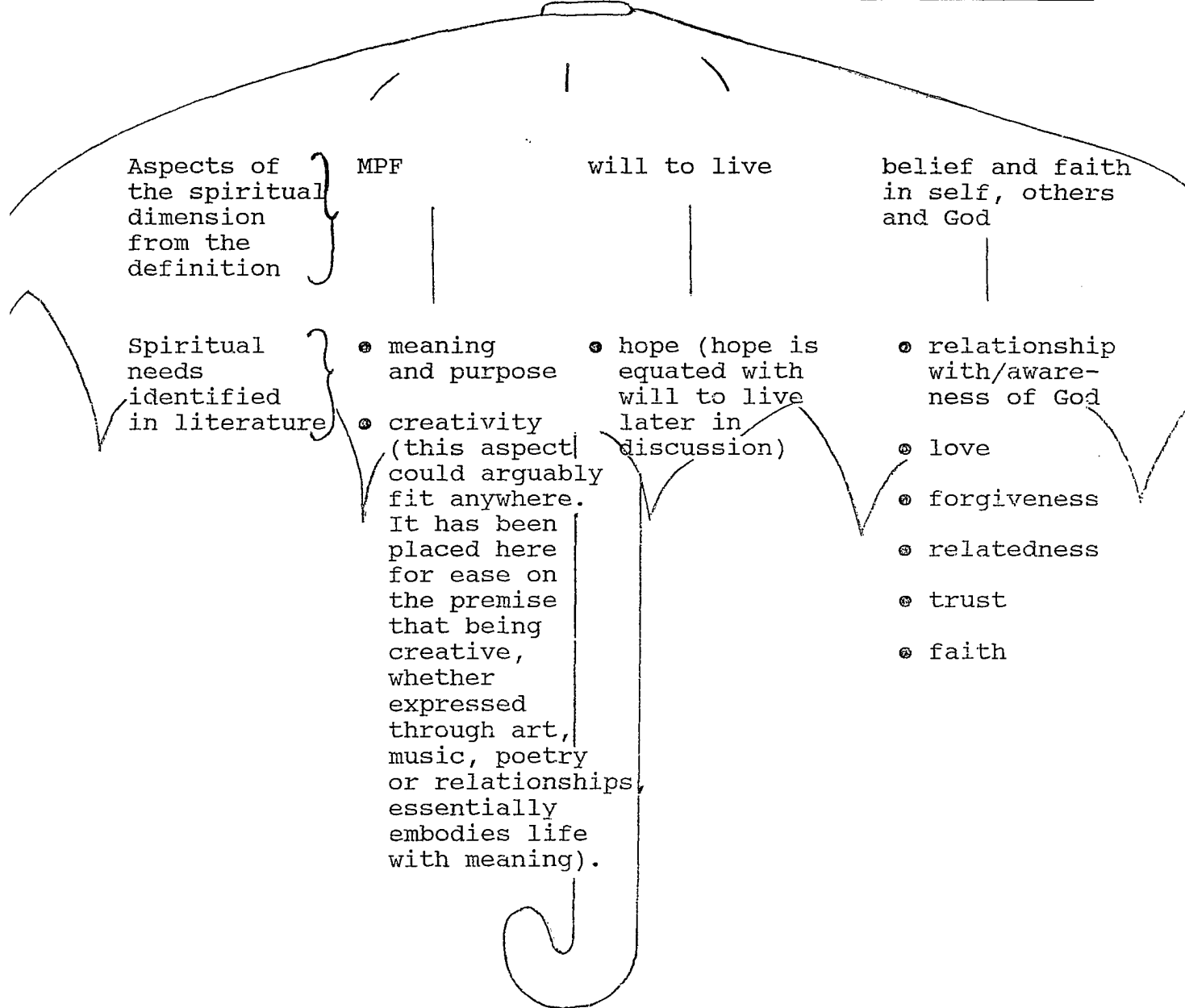
According to Maslow (in DiCaprio 1974), the meeting of "lower" or "deficit" needs (eg physiological/safety needs) is essential for survival, but to consider these needs alone is insufficient.

He holds that gratification of less obvious and more fragile "growth" needs, eg the need to "know and understand" and "find meaning in life" (clearly spiritual needs) is just as important.

In Maslow's opinion, the fulfilment of these needs is essential for the attainment of self actualisation, which he regards as the force for growth, without which one cannot fulfil:

"ones individual nature in all its aspects, being what one can be" (Maslow in DiCaprio 1974, p241).

FIGURE 3  
COMPARISON OF THE SPIRITUAL NEEDS IDENTIFIED IN THE LITERATURE  
WITH THE THREE ASPECTS OF THE SPIRITUAL DIMENSION DEFINITION



It is through this self-actualisation process, or state of "becoming", that ultimate fulfilment and satisfaction are experienced (Maslow 1970) and total healthy functioning achieved. Maslow thus regards the tension produced from growth needs (spiritual needs) as positive. Selye (1980) similarly considers "good" or "eustressing" stressors as essential motivators enabling the individual to experience achievement and fulfilment. Given Maslow's (in DiCaprio 1974, p422) definition of "need" as:

" a deficit state, a lack of something that is required"

a "growth need " could be defined as:-

"a lack of something that produces growth".

If a spiritual need is a growth need, it could be defined thus:-

"a lack of any or all of the following required to produce growth: meaning, purpose and fulfilment in life; the will to live; belief and faith in self, others and God."

Maslow postulates that if need deprivation is experienced some form of illness results. Spiritual distress could, therefore, be defined as:-

"the state resulting when an individual is deprived of having their spiritual needs fulfilled."



Just as it is possible to experience spiritual distress, it is also possible to experience the opposite state, i.e spiritual well-being. This can, therefore, be defined as:-

"the overall state of spiritual health which is evidenced by the presence of: MPF in life; the will to live; belief and faith in self, others and God."

It is evident, therefore, that well-being, health and quality of life are essentially dependent on the extent to which spiritual needs are satisfied.

Although Maslow (in DiCaprio 1974) holds that deficit needs should be met to a certain extent before growth needs can be considered, he also acknowledges that this is not always necessary. Thus, although biopsychosocial well-being is dependent on the degree of spiritual well-being (e.g the effect of loss of hope), the latter can be attained and self-actualisation continue, despite the degree of biopsychosocial well-being (eg the person who suffers incredible physical torture rather than give up their faith).

Having described and defined spiritual need, it would appear that for the attainment of an optimum state of health, quality of life or well-being, spiritual needs require to be met.

#### 4 Evidence for the influence of the spiritual dimension on health, well-being and quality of life

So far, the influence of the spiritual dimension on health, well-being and quality of life has merely been argued and is summarised by Jourard (in Hitchens 1988, p17) when he states:

"...hope, purpose, meaning and direction in life produce and maintain wellness...whereas demoralisation by events and conditions of daily existence help people become ill."

Support for the influence of the spiritual dimension on health, well-being and quality of life is presented by considering each component of the spiritual dimension in turn, as available in the literature.

##### Meaning and purpose

Taking the first component, according to Yura and Walsh (1982, p 90):-

"the greatest task of human kind is to determine the meaning of life"

Stoll (in Rinear and Buys 1985, p 867) states:

"It has been said that man needs reasons for living and if there are none he begins to die".

Furthermore, Frankl and Travelbee (in Dickinson 1975), together with many other authors, regard this as a universal trait which is essential to life itself (Autton 1980, Colliton 1981).

Burnard (1989) and Frankl (1959) assert that, when there is an inability to invest life with meaning, spiritual distress is the outcome characterised by feelings of emptiness and despair.

The necessity of meaning in life is similarly reflected in a number of psychological theories. McClymont et al (1976) report how both Jung and Peck postulate respectively that meaning is necessary for the maintenance of ego integrity and for the prevention of restlessness and deterioration in old age.

Furthermore, a number of research studies highlight the importance of meaning in life for health and well-being.

Simsen (1985) found that medical and surgical patients demonstrated a need to find meaning in their illness and hospitalisation. Although based on a small sample of 45 patients in a specific area in England, the study indicates that, within the sample, search for meaning was a significant experience for these patients. This was one of the few British studies addressing spirituality.

Kobasa (in Martin and Carlson 1988) reported fewer negative stress symptoms in individuals who were committed to and found meaning in their work. Detailed information about the method used was, however, not available and hence validity and reliability of the results were not clear. Also Antonovsky (1979) and Frankl (1959), in their observations of holocaust victims, reported survival, minimal psychological damage and even strengthening of character in those who had managed to maintain a sense of meaning and purpose in their lives throughout their ordeal.

Renetzky (1979) sought to discover the relationship between MPF, as measured by the "Personal Well-being X-Ray" (Figure 4), and spiritual well-being, as measured by the extent of the religious role within an individual, which as already stated can act as an avenue through which the spiritual is expressed. As human life primarily consists of a number of inter-related roles, it is to be expected that MPF will normally be achieved through these roles.

Given that the percentage of MPF obtained from a role is not necessarily related to the length of time or amount of energy expended on it (eg. it is possible to spend a long time in a role but achieve little MPF) then it is possible for there to exist a degree of emptiness or "void" within an individual (as

FIGURE 4  
THE MEASUREMENT OF PERSONAL WELL-BEING USING THE PERSONAL  
WELL-BEING X-RAY

(adapted from Renetzky 1979, pp 216-217)

MALE ROLES*	MPF;	Meaning	Purpose	Fulfilment
1 Husband				
Divorcee				
Widower				
Sweetheart				
2 Father				
3 Job (breadwinner)				
4 Son				
5 Brother				
6 Uncle				
7 Grandfather				
8 Self				
9 Friend				
10 Religion				
11 Student				
12 Maintenance man				
13 Others				
14 Void				
		100%	100%	100%

\* Corresponding female roles

1 Wife	8 Self
Divorced	9 Friend
Widow	10 Religion
Sweetheart	11 Student
2 Mother	12 Home maker
3 Job (breadwinner)	13 Others
4 Daughter	14 Void
5 Sister	
6 Aunt	
7 Grandmother	

The client is asked to identify the particular roles which make up his life, and to assign to each role the percentage of meaning, purpose and fulfilment derived from each (cannot exceed 100%). From this the degree of void and MPF as a whole can be indicated, thus giving some idea of the quality of life experienced by the individual.

highlighted by Burnard 1989 and Frankl 1959). If the attainment of MPF is vital to life, then a large amount of "void" is detrimental to the individual.

Out of a 1000 cases in his clinical experience (he does not detail the selection of the sample) Renetzky found that as MPF increased so did the role of religion and the degree of healthy self love (as measured by "the self wheel", a tool developed using a 1-10 scale). A decrease in the "void" equated with an increase in spiritual well-being.

The findings of this single study conducted in the USA cannot be generalised. However, it supports the supposition that, as MPF increases, so does the level of spiritual well-being and consequently quality of life and health.

To summarise this section, it would appear that the quest for MPF in life is fundamental to the attainment of an optimum state of health, well-being and quality of life.

#### Will to live

The second component of the spiritual dimension is the individual's "will to live," the importance of which is illustrated in the following quotation from Proverbs 18:14 (in Holy Bible):-

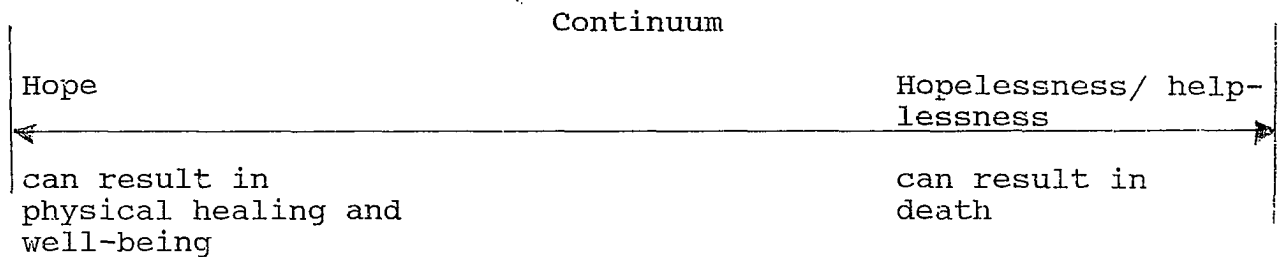
"...Your will to live can sustain you when you are sick, but if you lose it, your hope is gone."

It can also be seen from this quotation that the "will to live" and "hope" are inseparably linked, the latter having been defined as:-

"...to desire with belief in the possibility of fulfilment" (Kirkpatrick 1983, p 604).

As such, hope has been regarded as a major motivator of behaviour, acting as a powerful life force, producing vitality and liveliness in life (Dubree and Vogelpohl 1980). Widespread documentation gives evidence of the fact that without it, death can result. For instance, both animal and human studies show that prolonged and repeated encounters with situations, which although not life threatening are unavoidable, and in which the outcome is independent of all voluntary responding, produce helplessness/hopelessness. The end product of this is frequently death. Such instances include voodoo death and concentration camp experiences, as cited by Cannon and Burrell (in Seligman 1974), Bettelheim (in Seligman 1974) and Frankl (1959) respectively. Furthermore, although a causal link is difficult to identify, Blenkner (1967) noted higher mortality rates in elderly people who had been involuntarily institutionalised. It is because of its often drastic effects that helplessness/hopelessness has been appropriately termed as "passive suicide" (Limandri and Boyle 1978, p 79).

The importance of hope to life can be seen, not only in death caused by its absence, but also in healing produced by its abundance. These two states demonstrate the extremes of the hope-hopeless/helplessness continuum :-



Evidence for the positive effects of hope can be seen in clinicians' observations of clients over a number of years. For instance both Renetzky (1979) and Swaim (1962) reported that the greater the will to live, the greater the chance their clients had of overcoming illness.

A different type of evidence which reports non-verifiable events, illustrates the positive effects of hope. For example Gardner (1983) and Tari (1978) document numerous instances of miraculous events e.g healing of the deaf and blind, raising of the dead where hope and also faith in God were central. These instances are hardly surprising if, as McGee (1984) states, the degree of hope is related to the perception of the individual with regard to what is desired as probable. The bigger one's concept of God, the more things become possible and obtainable.



It is in recognition of the importance of hope that Dominian (1983), a psychiatrist, acknowledged that medical prognosis cannot be established on the basis of scientific data alone, but must be made in conjunction with the hope displayed by the patient.

It would appear, therefore, that hope or a will to live is vital to life itself.

#### Belief and faith in self, others and God

The third component of the spiritual dimension is that of "belief and faith in self, others and God".

In over thirty years working as a sociologist, Renetzky (1979) reported his observation that, as an individual's belief in himself and others increases, so does his will to live. Furthermore this latter aspect, together with MPF and spiritual well-being, were increased to a significantly greater degree when there existed, in addition, belief in God. Consequently there was virtual extinguishing of the "void".

Renetzky (1979) reported that the factor above all else which appeared to influence the individual's spiritual well-being, and hence their state of health and quality of life, was belief in God.

Just as belief is important in the attainment of spiritual well-being, health and a quality of life, this is also true of faith.

It is important to distinguish between these two concepts, in that it is possible to have belief without faith, yet impossible to have faith without belief, eg. one can believe that people exist, yet fail to have faith in them, however one cannot have faith in them without first believing that they exist. Faith then, can be viewed as belief in action, the latter having become personal and meaningful.

Renetzky (1979) reported that spiritual well-being was greatest in those who had invested belief and faith in God. Not only were they able to cope more calmly throughout difficulties, but they also possessed a higher MPF and will to live and a lower "void" than those who had no faith in God. Furthermore, as the individual's concept of God became bigger, so these attributes increased even further in degree, as did their quality of life.

Other studies have indicated the influence of belief and faith on health. O'Brien (1982) noted that patients who possessed a positive religious perspective on life adapted more readily to the stress of haemodialysis. Martin and Carlson (1988) reported the findings of two studies by Carlson et al (1986) and Byrd (1984) which indicated the therapeutic effect of faith in reducing anger, anxiety, pulmonary oedema and need for antibiotic

therapy, and intubation respectively. However, Martin and Carlson (1988) question these findings given the biased samples used and absence of tests to determine statistical significance.

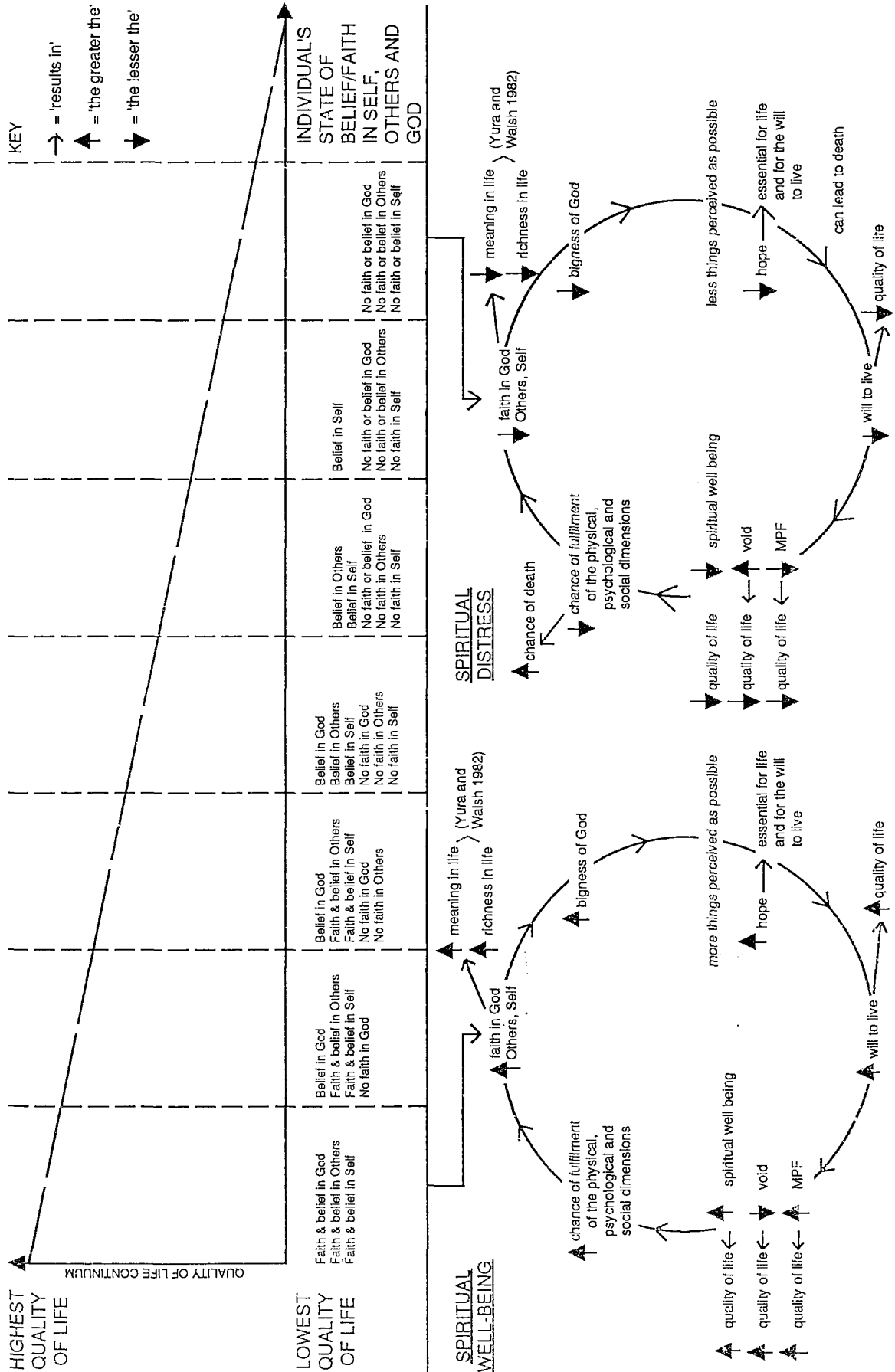
Although further research is indicated to test these observations, it would appear that the optimum state of health, quality of life or well-being, can only be attained when MPF in life, a will to live and belief and faith in self, others and God exist (Figure 5).

## 5 Illness and hospitalisation as spiritual encounters

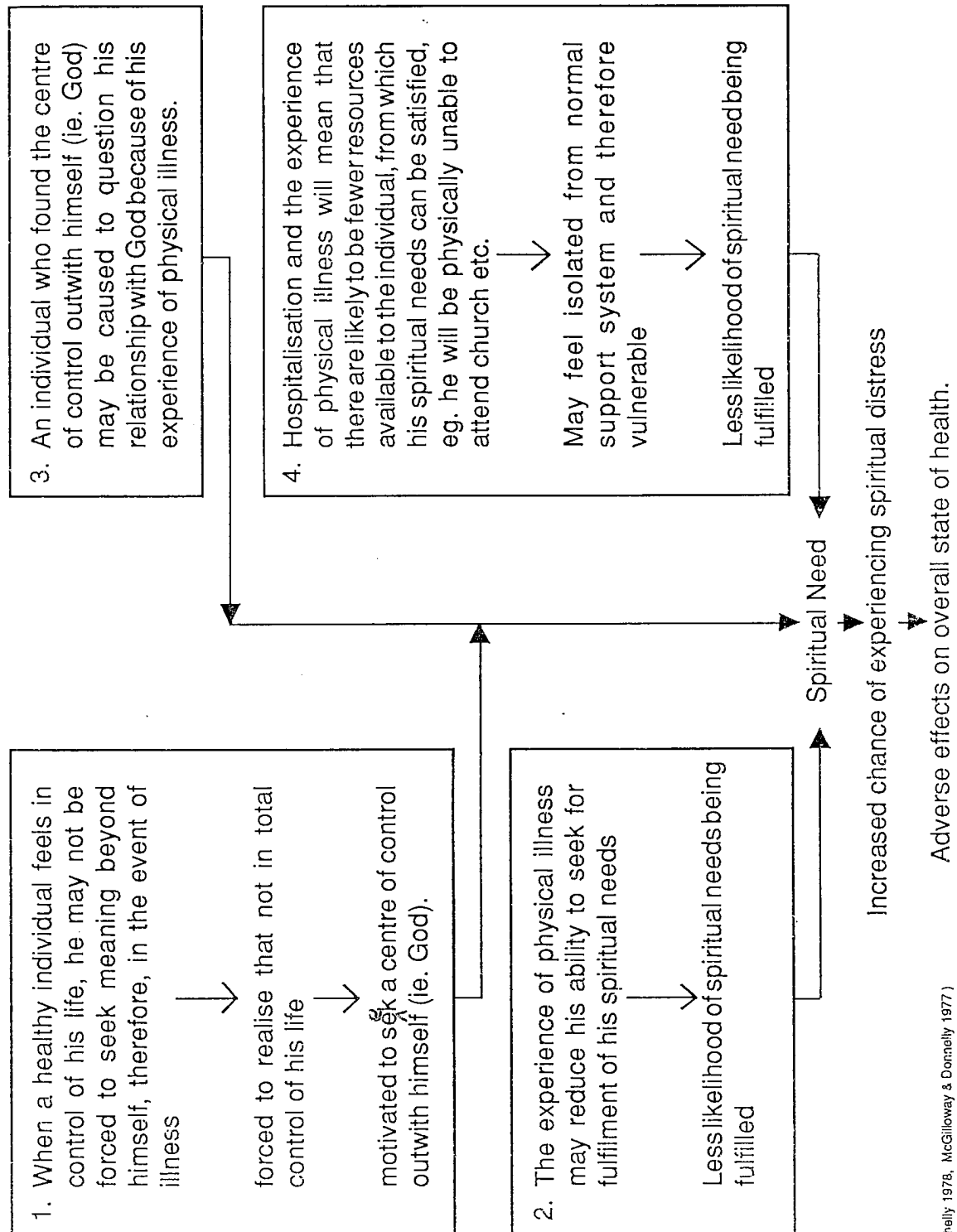
The spiritual dimension has been discussed with reference to healthy people who achieve need gratification, first by being motivated, and then by initiating action. There are however, a number of forces which can interfere with the ability of an individual to seek need fulfilment. Illness and/or hospitalisation are two such forces. The ways in which they can interfere with the gratification of spiritual needs, and hence the attainment of an optimum state of health, well-being and quality of life, are illustrated in Figure 6.

It may be that the experience of illness/hospitalisation causes some individuals to face loss of control for the first time in their lives. As Granstrom (in Hitchens 1988, p26) states:

FIGURE 5: QUALITY OF LIFE CONTINUUM II



**FIGURE 6**  
**WAYS IN WHICH ILLNESS AND/OR HOSPITALISATION**  
**CAN PRECIPITATE SPIRITUAL DISTRESS**



(Fitch and Shelly 1978, McGilloway & Donnelly 1977)

"Many individuals do not seriously search for the meaning and purpose of life but live as if life will go on for ever...Often it is not until the crisis, illness...or suffering occurs that the illusion (of security) is shattered...Therefore, illness, suffering...and ultimately death, by their very nature become spiritual encounters as well as physical and emotional experiences."

For many patients, therefore, spiritual care will be a necessary part of their total care.

This section has centred on describing and defining the spiritual dimension. It has been suggested that spiritual well-being and the meeting of spiritual needs, both in health and illness, are necessary for the maintenance of life itself and the attainment of an optimum state of health, well-being and quality of life. The experiences of illness and hospitalisation have been presented as crises which can precipitate spiritual distress and threaten the attainment of these goals. Given this, it is necessary to consider whether or not spiritual care should be part of the nurse's role (Section 3). As a prelude to this, an historical account of the changing philosophies of health care is given in Section 2.

## SECTION 2    CHANGING PHILOSOPHIES OF HEALTH CARE: AN HISTORICAL OVERVIEW

This section traces the changing philosophies of health care through the ages. It begins with the concept of man in his wholeness followed by the dualistic approach where physical and mental states were considered separately. Finally attention focuses on the slow re-emergence of the holistic concept today.

Most ancient civilisations were very much aware of the importance of phenomena, other than those directly observable, in influencing the disease process (Myco 1985 a). Religion was one such acknowledged phenomenon, man's beliefs and relationship, or lack of them, with God, having a significant effect on health.

From as early as the fifth century B.C., Hippocrates recognised that if the physician was truly to understand medicine, then he must also have a grasp of who and what man is. Thus, in traditional western medicine the body and soul were regarded as being inseparably linked, as evidenced by the way in which medical and spiritual care were provided within the one unit, eg "Knights Hospitallers of St John" (Yura and Walsh 1982). Plato (in Grubb 1977, p33) stressed the danger of failing to provide total care when he stated:-

"this is the greatest error in the treatment of sickness, that there are physicians for the body and physicians for the soul- and yet the two are one and indivisible."

Even Nightingale herself (in Colliton 1981, p492), a pioneer in the emergence of nursing, in 1892, described nursing as a "fine art" dealing with:-

"the living body - the temple of God's spirit".

However it was about a century ago that the importance attributed to the spiritual element of man was to change, the philosophy of care moving away from the holistic to the dualistic approach. It was here that the care of man's spirit and physique gradually separated, the latter increasing in importance while the former declined, no longer assuming the significance it once had (Penrose and Barrett 1982).

There are three main reasons for the divergence of care for the body and spirit, and the subsequent decline in importance of the latter. Each is discussed in turn below.

1) As a consequence of the rapid escalation in medical research, there emerged a period of enlightenment with regard to disease processes and treatments. As this approach relied heavily on measurable objective data, which the psychosocial and spiritual dimensions were incapable of producing, these dimensions of care gradually declined in importance. Meanwhile, medicine rapidly



accumulated a wide range of knowledge from its proliferating research, which awed and captured the attention of the day, becoming virtually the sole concern with regard to health.

2) Pre-occupation with this approach has continued to spill over into modern medicine, which is increasingly gaining a powerful influence in areas of life from which it was previously banned. Zola (1978 p254) has termed this process the "medicalisation" of society, the implications of which are discussed below.

Although the importance accorded to medicine is hardly surprising, given that health scores so highly on society's list of values, it is also very disturbing as:-

"science is not the only path leading to the truth"  
there being "many others which will lead us further"  
(Patey 1963, p3009).

The danger lies, not so much in the power and influence that medicine claims over health by its own contribution, but in the prevalence of the "medical model", which views illness exclusively within the boundaries of physiological dysfunction (Ironbar 1983). It is the fact that this approach excludes and denies the other dimensions of man and the contribution that they could make to the attainment of health, that is disturbing. As Nightingale (in Kramer 1957, p36) states:-

"the sick body...is something more than a reservoir for  
storing medicines."

Perhaps a greater danger than that of the medical model having assumed the right to define health and illness and determine what it considers to be the appropriate treatments, is that by considering only man's biological element, and even then differentiating it into smaller sub-units of study, he is being treated as less than human by the mere fact that he is not being regarded in his wholeness (Moberg 1979). Patient care consequently becomes fragmented and increasingly impersonal (Myco 1985 b).

Illich (1975) takes Zola's concept of the medicalisation of society further. He points out that the increasing variety of treatments provided by medicine, offering apparently unlimited improvement to health, can in fact have a negative effect. He has called this backlash of progress "medical nemesis" or "iatrogenesis". An obvious example is the side effects of nausea, hair loss and lethargy caused by radiotherapy. However, iatrogenesis can be more insidious e.g the effects of institutionalisation. Perhaps Lewis (in Lecture Notes 101, p2) had Illich's concept of Nemesis in mind when he said:

"man's power over nature is really the power of some men over other men, with nature as their instrument."

3) The third reason for the decline in the attention credited to the spiritual dimension, is the way in which the medical model has emphasised the process and mechanism of disease and illness,

rather than the meaning of it (Fish and Shelly 1978). As Nietzsche (in Fish and Shelly 1978, p42) states, it is not the "how" behind disease but the "why" and the "who" that is ultimately important. In other words, although it cannot be denied that the "how" behind disease may be significant for its prevention and cure, what really matters to man is the meaning he can find in all life's experiences, including illness and death. According to Illich (1975) medicine has rendered illness, suffering and death meaningless. He cites this as another example of iatrogenesis.

It is clear that the approach of the scientific era, almost a century ago, and its development since then, resulted in a dualistic health care system, the consequence of which was that physiological care increased in importance while the spiritual dimension declined and even became an embarrassing subject, as illustrated by the cartoon below. Although the medical model is still prevalent in health care today, the last thirty years have witnessed a rising recognition and concern that this approach to health is insufficient. This, together with the fear of the dehumanisation which could result from subdividing man into smaller and smaller fragments for the sake of scientific examination and discovery, has resulted in dissatisfaction with the medical model and consequently the re-emergence of the holistic concept (Hamel-Cooke and Cope 1983).

**IT'S UNHEALTHY THAT  
ALTHOUGH SEX IS NO LONGER  
TOO PRIVATE TO TALK  
ABOUT, RELIGION STILL IS.**



**CATHY FOR GLAMOUR**

Interest in the holistic concept of health is evidenced, first, by the emergence and rising popularity of complementary medicine (Peck 1981). The recent shift in terminology from "alternative" to "complementary" medicine perhaps further emphasises the move toward holism. Techniques such as visualisation, biofeedback, massage and aromatherapy, to mention only a few examples, highlight the vital role played by the mind in controlling body processes (Burns 1980, Rachman and Philips 1978).

Secondly, there has been the introduction of the "holistic" health care concept, where all aspects of man are regarded as important to his total state of well-being (Tubesing 1979). Although this approach is more prominent in the USA, the central philosophy has been adopted in Britain's hospice movement, where spiritual care is given particular attention in the care of the dying.

The final example which highlights the desire to give holistic care, can be seen in the Marlebone project in London, where the clergy and medical staff collaborated in caring for the sick by forming a unit whose sole concern was to facilitate healing of the whole person (Hamel - Cooke and Cope 1983).

In conclusion, from this historical account of the changing philosophies of health care, it is evident that the spiritual dimension has received varying degrees of attention over the years, depending on the particular conviction of society with

regard to health at that time. Health care provision has thus come virtually full circle. It has moved from the rather mystical combination of religion and medicine in past centuries, to their divergence during the scientific era. Finally, their tendency to re-combine is evidenced by the way in which attention is swerving away from obsession with biological processes, in an effort to re-discover man in his wholeness.

### SECTION 3 SPIRITUAL CARE - SHOULD IT BE PART OF THE NURSE'S ROLE?

Having looked at how the concept of health care has changed over the years, the issue of whether or not spiritual care should be part of the nurse's role is addressed in this section. This is achieved by examining definitions of nursing, Codes of Conduct, models of nursing and guidelines for nurse education, each of which is discussed in turn.

#### 1 Definitions of nursing

Definitions of nursing state that it is the responsibility of the nurse to:

"..promote health, to prevent illness, to restore health and to alleviate suffering" (ICN 1973)

"..assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge" (Henderson 1977, p4).

Central to these definitions is the nurse's role in assisting patients to achieve their maximum health potential (Rogers 1970 p86). It has already been established that the level of health achieved by an individual will ultimately depend on the extent to which their spiritual needs are met. It is clear, therefore, that if nurses are to fulfil their function of promoting health,

then spiritual care is a nursing responsibility and not an optional extra. It is necessary at this point to define spiritual care.

Nursing is a caring profession (Hargreaves 1979) involving itself in helping patients meet needs conducive to health (Henderson 1977). Given this, together with the fact that "to take care of" has been defined as:

"to make necessary arrangements regarding" (Kirkpatrick 1983, p190)

spiritual care could be defined thus:

"to make necessary arrangements for the provision of patients' spiritual needs".

In addition, a number of nursing authors such as Travelbee (1977) and Henderson (in Henderson and Nite 1978) mention spiritual care explicitly. They acknowledge the need to find meaning in life and suffering which has already been identified as a spiritual need. Travelbee (in Fish and Shelly 1979, p59) goes further, however, and states that:

"...the existence of suffering whether physical mental or spiritual is the proper concern of the nurse."



## 2 Codes of Conduct

Both national and international Codes of Conduct support spiritual care as a nursing responsibility.

Taking the former first, the UKCC states that it is the duty of the nurse to:

"Take account of the customs, values and spiritual beliefs of patients/clients" (UKCC 1984 a, p2).

Furthermore, it considers this to be:

"...a statement to the profession of the primacy of the interests of the patient or client" (UKCC 1984 b, p4) which "...places paramount importance upon the interests of patients and clients and the standard of their care" (UKCC 1991, p6) and is "...a portrait of the practitioner which the Council believes to be needed and which the Council wishes to see within the profession" (UKCC 1984 b, p4).

Thus the UKCC acknowledges that spiritual beliefs are of prime importance to the patient and that attention to these should similarly be reflected in nursing practice. A recent study conducted by the Nursing Times (Diamond 1991) found that all Health Authorities, Health Boards and Trusts participating considered that the nurse had an obligation to work within the Code of Professional Conduct. The UKCC (1984 b, p4) also describes its pronouncement concerning nurses taking account of patients' spiritual beliefs, to be a:

"...clear unequivocal statement of the profession's values..." (UKCC 1984 b, p4).

However, rather than being "clear", this declaration appears rather ambiguous. For instance "to take account of" could be interpreted in a rather passive way where the nurse is not actively involved in helping patients meet their spiritual needs. Alternatively, it could be interpreted to mean the nurse being actively involved in helping patients with these needs. Furthermore, the definition of "spiritual beliefs" is open to interpretation. For example, it could be viewed in terms of religious beliefs only or in the broader context including the needs for MPF, hope etc.

Concerning international codes of conduct, the ICN (1973), considers its Code for Nurses to be:

"...a guide for action based on values and needs of society..." and states that "The nurse, in providing care, promotes an environment in which the values, customs and spiritual beliefs of the individual are respected."

Thus the spiritual beliefs of the individual are recognised and valued by the Council, so much so that this is reflected in its guidelines for nursing practice. However it is unclear what is actually meant by "respecting" patients' "spiritual beliefs" and "promoting an environment" in which this can be achieved. The fact that the ICN (1977, p14) considers the nurse:

"...best able to assess the operating...beliefs and incorporate her knowledge of them in directing the nursing care..."

suggests an active rather than a passive role for the nurse in respecting patients' spiritual beliefs. Perhaps this lack of clarity is due to the fact that the Code does not purport to act as a law but rather as a guide providing nurses with:

"...a broad statement of the nurse's responsibility as a professional person" (ICN 1977, p vii).

Because it was unclear what the UKCC and ICN meant by their statements, the researcher decided to write to them to ask for an explanation. Neither organisation could give this, however, it is worthy of note that the statements concerning patients' spiritual beliefs had been added to the Codes. The UKCC's statement was considered a necessary addition because the Council felt that practitioners often ignore patients' spiritual needs. Concerning the ICN, their statement was added to the Code following its review in 1973.

It would appear, therefore, that Codes of Conduct acknowledge spiritual care as a necessary and valued part of the nurse's role. Although it is not clear what is actually expected of the nurse, the fact that in both cases these were additions to the

Codes perhaps reflects increasing recognition of the influence of the spiritual dimension on health and illness as suggested in Section 2.

### 3 Models of nursing

Models of nursing include consideration of the spiritual dimension either directly or by ~~considering~~ man's wholeness and search for meaning.

Considering those which do so directly, Henderson (1977, p13, 19) states that it is the duty of the nurse to assist the patient to:

"worship according to his faith" and "practice his religion or conform to his concept of right and wrong".

She interprets spiritual need in the religious context and contends that if religious practice is essential to the individual's sense of well-being in health, then it will be all the more necessary during illness.

Ways in which she suggests the nurse can help patients practise their religion are by:

- o enabling them to attend a place of worship

- o contacting and involving appropriate clergy in the patient's care
- o providing privacy for patient and clergy
- o making necessary arrangements for them to receive the sacraments.

Watson (in Riehl-Sisca 1989) also includes the spiritual dimension in her model of nursing. Rather than concentrating on the religious aspect she views spirituality in the broader context of the individual's need for meaning and harmony in existence and for transcendence to a higher level of consciousness. She postulates that if the individual is to experience true wholeness, then he must live in contact with and feed his soul/spirit which is the very core of his being. It is through the soul that the individual can transcend the here and now and co-exist simultaneously with the past, present and future, thereby becoming fully integrated and self-actualised. These are similar ideas to those of Brewer (1979) and Maslow (in DiCaprio 1974) presented in Section 1. According to Watson, disease/illness can cause or be caused by disharmony in the individual's inner self. The goal of nursing is, therefore, to assist them to achieve inner harmony from which will emanate self healing. This can be achieved through the "caring" action of the nurse who is required to be sensitive in order to nurture faith and hope in the patient.

Both Rogers (in Riehl-Sisca 1989) and Weidenbach (in Fitzpatrick and Whall 1983) give consideration to the spiritual dimension by ascribing to man's wholeness, of which the spiritual is part.

Fitzpatrick's Rhythm Model (in Fitzpatrick and Whall 1983) includes consideration of the spiritual dimension by concentrating on man's search for meaning which has already been identified as a spiritual need.

Other models such as Roy's Adaptation Model and Neuman's Health Care Systems Model, have been criticised (in Riehl-Sisca 1989) for failing to incorporate the spiritual dimension overtly. Some authors have, therefore, adapted them to include this. The only British model i.e that of Roper et al (1985) omits the spiritual dimension.

#### 4 Guidelines for nurse education

Finally, both British and international guidelines for nurse education indicate that spiritual care should be taught to nurses.

Taking the UK first, in preparation for Project 2000 it has been recommended that nurse education should:

"...provide opportunities to enable the student to...acquire the competencies required to: xiv) identify...spiritual needs of the patient or client,

devise a plan of care, contribute to its implementation and evaluation by demonstrating an appreciation and practice of principles of a problem solving approach." (UKCC 1986, pp40-41).

This is further reflected in Scotland in the NBS's consideration of the reforms for basic nurse education. Amongst its aims and objectives is that the nurse will be enabled to:

"assess, plan, implement and evaluate care to meet the...spiritual...needs of the individual and family/friends." (NBS 1990, p16)

In short, in the UK, nursing students are to be taught how to give spiritual care using the Nursing Process.

On the international scene the ICN (1973) which, as stated previously, includes spiritual care in its Code for Nurses, considers the Code:

"...will have meaning only if it becomes a living document applied to the realities of human behaviour in a changing society" and that "In order to achieve its purpose the Code must be...put before and be continuously available to students...throughout their study and work lives."

Furthermore the AACN (1986, p5) recommends that the education of the professional nurse should ensure her ability to:

"Comprehend the meaning of human spirituality in order to recognise the relationship of beliefs to culture, behaviour, health and healing"

and to plan and implement this care.

In conclusion, having examined definitions of nursing, Codes of Conduct, models of nursing and guidelines for nurse education, it is suggested that spiritual care is a nursing responsibility and not an optional extra. This raises the question of whether or not nurses actually practise spiritual care. This issue is addressed in Section 4.



#### SECTION 4 SPIRITUAL CARE - IS IT PRACTISED BY NURSES?

Having illustrated that spiritual care should be part of the nurse's role, attention now focuses on whether or not this would appear to be the case in practice. This is achieved by reviewing the current nursing literature and research with regard to spiritual care.

##### 1 A review of the literature

Five books were located which are specifically devoted to spiritual care in nursing. Three are American. Two of these are written by nurses affiliated with the Nurses Christian Fellowship (NCF) (Fish and Shelly 1978, Shelly and John 1983). The majority of contributors in the other publication are nurse educators based predominantly in the nursing department of one university (Carson 1989).

The two other books are British. The most recent is written by a nurse tutor (Narayanasamy 1991) and the other contributed to mainly by nurse educators in Northern Ireland but also clergy (McGilloway and Myco 1985).

Concerning the content of the books, those of Fish and Shelly (1978) and Shelly and John (1983) are written predominantly from a Christian perspective. Although they are somewhat vague, they provided the launch pad for future literature on the subject.

Those of McGilloy and Myco (1985) and Carson (1989) are the most comprehensive giving an historical account of spirituality, outlining the religious practices relevant to different faiths and applying spiritual care to different settings e.g acute illness, giving specific patient examples. Furthermore, in Carson's (1989) book there is a good overview of the concepts of spirituality, spiritual need, spiritual well-being and spiritual distress.

Some other nursing texts were found to contain chapters on spirituality. A British text by Henderson and Nite (1978) contains a chapter entitled "Worship" which concentrates mainly on religious aspects of spirituality. Other American texts such as Murray and Zentner (1975) and Beland and Passos (1975) include chapters which basically summarise the information presented in the books specifically on spiritual care.

In addition to text books, there has been a proliferation in the number of journal articles written on spiritual care in recent years, as can be seen from the reference list. Most of these articles are anecdotal. Few are research-based and most are American.

In summary, having reviewed the literature on spiritual care, it would appear that the majority of texts agree that nurses should be giving spiritual care, however, operational definitions of "spiritual" and "spiritual need" are lacking as are guidelines for the practice of spiritual care.

## 2 A review of nursing research on spiritual care

It would appear that research is very much in its infancy, few studies having been undertaken. Furthermore, the ability to generalise findings is limited by the fact that the majority of studies are American in origin. Only two British studies were identified (Chomicz 1984, Simsen 1985) neither of which looked at the nurse's perspective. Also, in addition to the fact that many of these studies are now rather outdated, most researchers used small samples of convenience and tools which had not been tested for reliability or validity. Moreover comparison between studies is made difficult by the fact that operational definitions of terms are frequently lacking or are not cited in summarised versions of the original studies. There is no guarantee, therefore, that the terminology used is consistent across studies.

Bearing these limitations in mind, an overview is given below of this small, but growing, body of research by looking first at studies which address the patient's perspective of spiritual need and spiritual care followed by those concerned with nurses' opinions and nurse education.

Five studies were identified which looked at the patient's perspective on spiritual need and spiritual care. These are presented in chronological order.

#### Study 1

In 1969 Stallwood-Hess endeavoured to determine patients' awareness of their spiritual needs. Twelve nurses from the NCF interviewed 109 patients who were not critically ill. These patients were selected from a number of hospitals and had been in-patients for three or more days. Examples of questions asked were:

- o were you aware of having a spiritual need at any time during your hospitalisation?

- o has your need been met to any degree or is it still present?

The findings revealed that spiritual needs expressed by patients were for, in rank order:

- o prayer
- o relief from loneliness
- o awareness of God's presence
- o relief from fear of surgery and death
- o meaning and purpose in life, death and suffering
- o relief from guilt, loss of faith, doubt
- o expression of their faith by visible means.

It was not reported whether or not any patients had stated that they experienced no spiritual needs.

Patients sought assistance with meeting their needs first from the clergy followed by the nurse, then others such as family and friends. The majority were satisfied with the help they had received. Others indicated that their need had only been partially met whilst some (10%) had received no help at all.

When asked how they thought nurses could help them with their spiritual needs, some felt nurses were too busy whilst others stated they could help by:

- o listening
- o referring to the chaplain
- o talking with them
- o praying with them
- o "being there".

Thus, although Stallwood-Hess's study was limited by the fact that several interviewers were used, all of whom belonged to the NCF which could have introduced interviewer bias, it would appear that, within the sample, patients experienced spiritual needs while in hospital. These needs were, however, not always entirely met. Furthermore, patients considered the nurse to have a significant role in spiritual care.

## Study 2

Kealey (1974) interviewed 40 patients randomly selected from medical and surgical wards in four hospitals in a mid-western city in the USA, to determine what they perceived their spiritual needs to be. Interviews lasted between 30-60 minutes and included 45 questions.

She found that the majority of patients (60%) reported no spiritual needs during hospitalisation. Of those who did, needs they experienced included:

- o relief from fear of surgery, pain, dying
- o relief from loneliness
- o support from clergy
- o help to accept poor prognosis
- o reassurance of having made the right decision
- o someone to listen and understand
- o opportunity to participate in worship services.

Some patients would have liked spiritual help from the nurse, however, the majority did not see this as part of the nurse's duty. No patients had received help with their spiritual needs from the nurse but rather met their needs alone or with help from family, friends or clergy.

Kealey concluded that it should not be assumed that just because a person is hospitalised they will have spiritual needs. She acknowledged, however, that for some patients, having their spiritual needs attended to will be important.

### Study 3

Martin et al (1976) also sought to determine the spiritual needs hospitalised patients experienced. They used a self completion questionnaire combined with an interview to retrieve this information from 65 adults in two area general hospitals in the USA. Just under half (48%) of these patients said they had experienced spiritual needs such as for:

- o support
- o hope
- o relief from fear
- o comfort
- o meaning in suffering
- o relationship with God.

They had discussed their needs in the first instance with the clergy, then with family followed by the nurse. Whilst 29% felt their need had not been met, the majority considered it had been met in part.

Patients considered that nurses could give spiritual care by:

- o listening
- o referring to the clergy
- o showing kindness, understanding
- o "being there".

However the majority of patients felt that nurses did not have enough time to do so.

#### Study 4

Chomicz (1984) sought to investigate patients' experiences of spiritual need by conducting semi-structured interviews with a volunteer sample of 30 orthopaedic patients from three wards in a London teaching hospital.

She found that 29 out of 30 patients stated they had experienced a spiritual need during their hospitalisation. The most commonly cited needs were (in rank order):

- o for help to trust God more



- o lack of peace
- o lack of meaning in suffering
- o loneliness.

Half would have been glad to talk to a nurse about their need and the majority had not seen a chaplain but would have liked to.

#### Study 5

Simsen (1985) conducted 45 semi-structured interviews with patients in general medical and surgical wards in England. She found that illness and hospitalisation posed a threat to their physical integrity, confidence and personal relatedness. Religious practices e.g prayer, were highly valued by many patients and helped them to find meaning in their experience.

In summary, from the patient's viewpoint, with the exception of one study (Kealey 1974), nursing research indicates that for many patients illness and hospitalisation can become spiritual encounters as suggested in Figure 6. During these experiences a considerable proportion of patients reported spiritual needs (Chomicz 1984, Martin et al 1976, Stallwood-Hess 1969) and furthermore considered these of importance to them (Simsen 1985).

Some patients would have liked nurses to help them with their spiritual needs by such actions as listening, "being there" and referring to the clergy where appropriate (Chomicz 1984, Kealey 1974, Martin et al 1976, Stallwood-Hess 1969) however, many felt that the nurse was too busy to help in these ways.

Commonly expressed were the needs for: meaning; belief in God, often expressed through formal religious practices; relief from fear, doubt, loneliness; relatedness to others/God.

Although patients tended to express satisfaction with the assistance they had received (in Martin et al's 1976 study the majority were completely satisfied) Stallwood-Hess (1969) found that the majority felt their needs had not been met to the full. Furthermore, chaplains reported that, despite receiving excellent physical care, patients were often found to be struggling to grasp the meaning of their suffering (Bowlby 1980, Patey 1977).

Given that hospitalised patients considered their spiritual needs of importance, it would seem appropriate, therefore, that nurses should endeavour to help patients meet these needs. An overview of the research related to the nurse's perspective of spiritual care is given below.

Six American studies, dating from as early as 1957, sought to obtain nurses' opinions of spiritual care and their role in this.

### Study 1

In 1957 Kramer distributed questionnaires to 83 practising registered nurses in Oregon obtaining a 94% response rate. Details of the sampling method are somewhat sparse and the information sought was exclusively related to nurses' knowledge of various religious practices.

She found that, although the majority of nurses considered spiritual care part of total nursing care (93.6%), only 56.4% felt able to give this in practice. Nurses generally had a limited understanding of religious practices. Those who indicated the greatest ability to provide spiritual care had been in practice in excess of ten years.

### Study 2

Chance (1967) administered a questionnaire to 37 senior student nurses asking them about their identification of patients' spiritual needs. As all students were from Seventh Day Adventist Colleges, the results may be somewhat biased.

The majority of students (73%) said they had identified spiritual needs which included the need for faith and hope in and for love of God. They recognised these needs mainly through non-verbal

cues given by patients and responded by listening, praying with/reading the Bible to the patient or by contacting the chaplain.

### Study 3

In 1973 Chadwick distributed questionnaires to a random sample of nurses working in the Michigan area. The sample size is not stated, however the results are based on 34 returns. Again the emphasis was on religious needs.

All nurses felt that patients had spiritual needs and all stated they had identified at least one need.

Although half said they had never read the Bible to a patient, the majority of nurses (75%) said they would feel comfortable doing so. Over half (57.6%) felt patients' spiritual needs were adequately met, whereas 33.3% felt they were poorly met.

Furthermore, although the majority (81.8%) felt they had some knowledge of religious practices, most (60.6%) expressed the desire for further education in this respect.

#### Study 4

The second part of Kealey's (1974) study examined the nurse's perception of her role in spiritual care. Of the 24 questionnaires distributed to registered nurses, seventeen were returned. The responses revealed that, although the majority (91%) of nurses considered it was part of their duty to assist patients of various faiths to meet their spiritual needs, just over half felt able to do so. Appropriate activities reported by them were listening, reading religious literature if asked and referring to the clergy.

#### Study 5

Highfield and Cason (1983) distributed a questionnaire to 100 surgical nurses working in a large south western private hospital in order to examine their awareness of patients' spiritual needs. Based on the low response rate of 35%, they found that these nurses had a limited awareness of patients' spiritual needs. Only those behaviours related to specific religious beliefs and practices were identified with the spiritual dimension and these were thought to occur infrequently. (Similarly Fish and Shelly (1978) noted how, in practice, nurses placed primary importance on physical care, secondary importance on the psychosocial realm, but rarely considered the spiritual dimension.)

Although just over half (53%) had received education on spiritual care in their basic training (the nature or extent of this was not clear), few felt their greatest need was for further education in this area. Almost all expressed the desire for more teaching on psychosocial care.

#### Study 6

In a study of 300 registered nurses practising throughout the USA, Piles (1986) found that 96.5% considered holistic care to include spiritual care. Whilst 87.6% disagreed that only clergy could give spiritual care, 65.9% felt inadequately prepared to provide this. The nursing diagnosis of spiritual distress was used by 13% and 11% included spiritual needs, goals and interventions in nursing care plans. Few had been taught about spiritual care in their basic education programme, 78% felt that if they had known then they would have been able to give spiritual care and 89.2% agreed that spiritual care should be included in basic nurse education.

Factors found to be significant (at .001 level) in determining whether or not nurses gave spiritual care were:

- o the nurse's perceived ability to provide care
- o the degree of educational input in the nurse's basic programme

- o the degree of importance the nurse placed on spiritual care

- o obstacles the nurse perceived in providing spiritual care  
e.g lack of time.

In conclusion, research indicates that nurses were aware patients had spiritual needs (100% and 96.5% in the studies of Chadwick 1973 and Piles 1986 respectively) the majority (93.6%, 91% and 75% in Kramer 1957, Kealey 1974 and Chadwick 1973 respectively) regarding it their duty to make provision for at least some of these needs. Furthermore, according to Piles (1986) 87.6% of nurses disagreed that spiritual care was the remit of the clergy only. Despite this, however, it would appear that nurses had a limited ability to attend to the spiritual needs of patients.

Although Chance (1967) found that the majority of student nurses identified spiritual needs, these results may be somewhat biased. In addition, the basis on which over half the nurses in Chadwick's (1973) study concluded that patients' spiritual needs had been adequately met was unclear.

It is the general consensus of other studies, however, that despite the fact that nurses usually displayed some knowledge of and ability to identify the more obvious, direct religious needs e.g for communion (Chadwick 1973) they were less aware of spiritual needs than those pertaining to the psychosocial

dimension (Highfield and Cason 1983). Moreover they demonstrated a limited knowledge of and ability to help patients meet their spiritual needs (Highfield and Cason 1983, Kramer 1957).

Furthermore, Kramer (1957), Kealey (1974) and Piles (1986) found that whilst 93.6%, 91% and 87.6% of nurses agreed that spiritual care was a nursing responsibility, only 56.4%, 50% and 34.1% respectively felt able to provide for this adequately. This was a similar finding to Chadwick (1973) who also noted that, despite the fact that 75% of nurses stated that they would feel comfortable reading the Bible to or praying with patients, only 50% actually did so in practice. Additionally, in Kealey's (1974) study, patients with spiritual needs received no help from nurses.

The inadequacy felt by nurses in providing spiritual care was further borne out by the fact that, with the exception of Highfield and Cason's (1983) study, many expressed the need for further education in the meeting of such needs (Chadwick 1973, Piles 1986).

Therefore, generally, it would appear that practising nurses, cited in the forementioned studies, expressed the desire to be involved in giving spiritual care but felt inadequate in providing this.



With regard to spiritual care in nurse education it appeared that the teaching of spiritual care to nurses was a necessary pre-requisite to its practice by them. No research, however, could be identified which tested this assumption.

Furthermore, it seemed to be generally assumed that spiritual care was not taught, however, few research studies, certainly no British ones, were identified which addressed this issue. The author, therefore, decided to enquire of all basic nurse education establishments in Scotland with regard to their teaching input on spiritual care. This did not take the form of a questionnaire but merely a letter of enquiry to the person in charge of the establishment. From the responses received it would appear that spiritual care does not form a substantial identifiable component in any education programme e.g it may take the form of a one hour session from the hospital chaplain and be touched upon in religious practices in care of the dying.

Moves are being made, however, in the area of curriculum development. Piles (1986) postulated that three aspects must be present for learning to occur: student; setting; subject of study. She contended, however, that although the student may be present, the ward setting often discourages the practice of spiritual care and the teaching of spiritual care is often absent from nurse education programmes.

As early as 1957 Lewis set about developing a resource unit for the inclusion of spiritual care in the basic nursing curriculum at the University of Washington School of Nursing. Twenty volunteer students worked on a variety of spiritual care studies. Later, Hitchens (1988) found that students tended to project themes from their own faith, values and life experiences into patient care situations. Furthermore, rather than length of experience, life experience/crisis was a major factor in determining the level of the student's faith development (as measured by an interview developed by Fowler) which in turn appeared to influence the way in which students planned spiritual care. In addition, interpersonal skills e.g therapeutic use of self, were considered important by these students in giving spiritual care.

In conclusion the lack of research and literature on the teaching of spiritual care in nurse education programmes, together with the findings from a brief survey conducted in Scotland, tend to indicate that it is a subject not taught to any degree in basic nurse education programmes. This contradicts the recommendations, outlined in Section 3, given for nurse education.

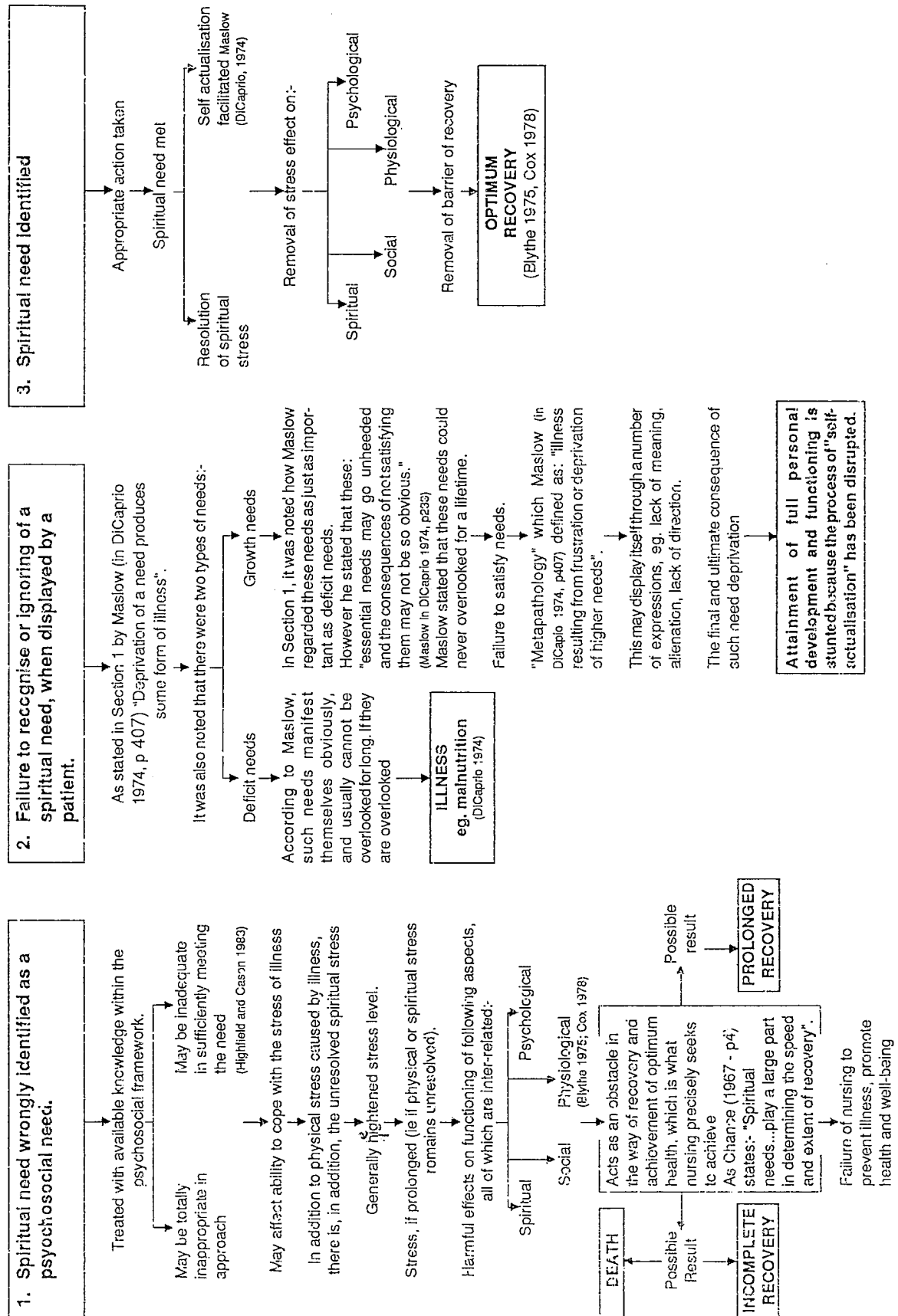
To summarise this section it would appear there is a lack of literature on spiritual care. The available literature is largely anecdotal, fails to reach a generally agreed definition of what is meant by "spiritual", "spiritual need" and "spiritual

care" and omits to give nurses guidelines for practice. There is a distinct lack of research on spiritual care, particularly of British origin. Bearing in mind the limitations of available studies, it would appear that patients experience spiritual needs but often these needs are not fully met, the implications of which could be serious as illustrated in Figure 7. In addition, patients consider that the nurse could have a significant role in giving spiritual care and nurses appear to be willing to do so but feel inadequate in this regard. Also, it would seem that, despite the fact that guidelines for education advocate the teaching of spiritual care, this does not occur to any great extent.

#### SUMMARY

In summary, having illustrated the influence of the spiritual dimension on health, well-being and quality of life (Section 1) and having established that spiritual care is a nursing responsibility (Sections 2 and 3), evidence has been presented which tends to indicate that patients' spiritual needs may not be well attended to in practice (Section 4). Although moves have been made to contribute to the knowledge base for spiritual care, this is very much in its infancy and nurses currently lack guidelines for practice.

**FIGURE 7**  
**THE IMPLICATIONS OF MEETING AND**  
**FAILING TO MEET PATIENTS' SPIRITUAL NEEDS**



## CHAPTER 2

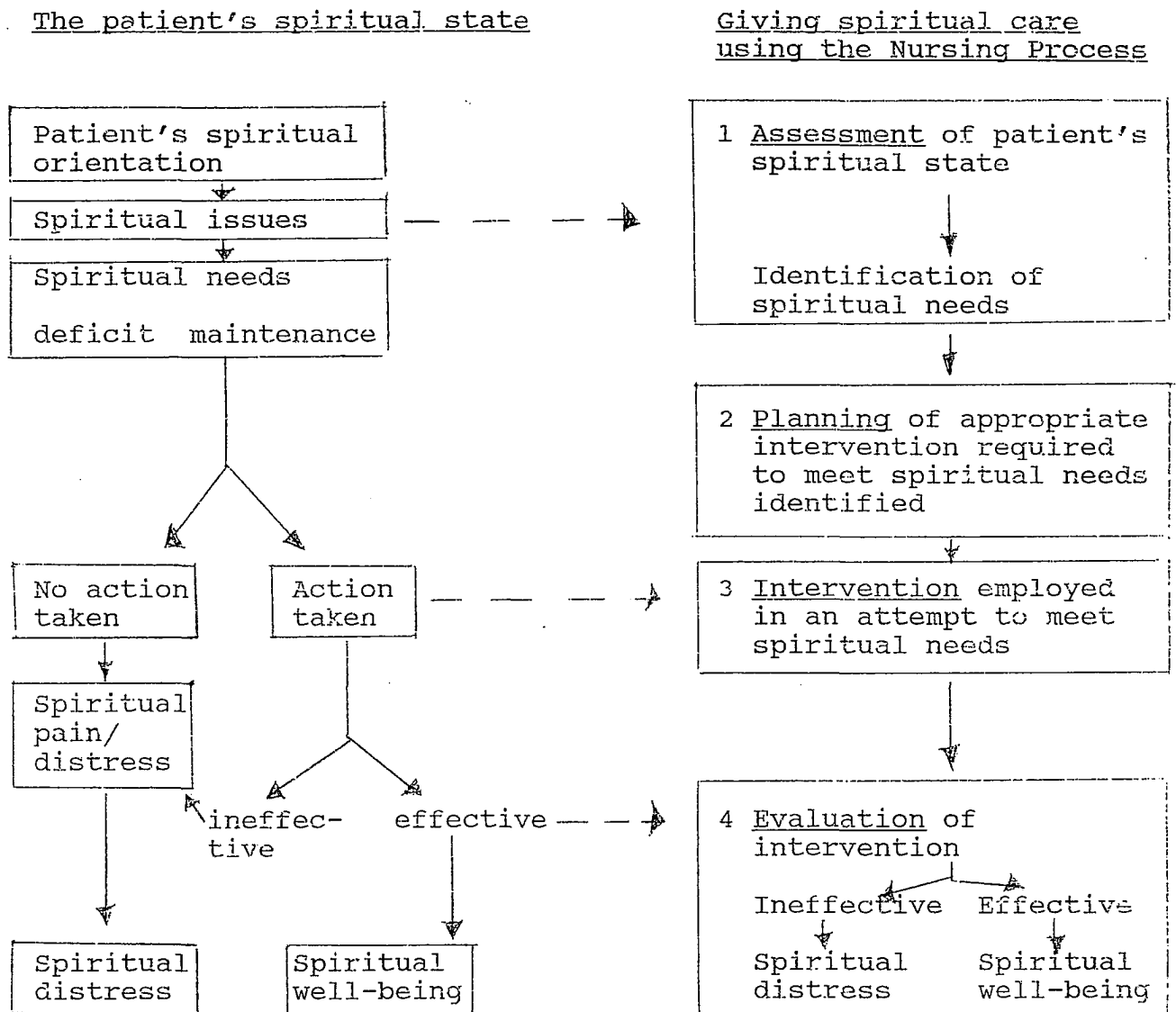
### PROPOSED CONCEPTUAL FRAMEWORK FOR GIVING SPIRITUAL CARE EMERGING FROM THE LITERATURE

Chapter 1 illustrated how there appeared to be insufficient knowledge and guidelines to enable nurses to give spiritual care. This chapter proposes a conceptual framework for giving spiritual care based on the Nursing Process (Figure 8) and is explained below.

An individual entering hospital will do so with a particular spiritual orientation. As described in Chapter 1, the experience of illness/hospitalisation may cause them to experience spiritual needs for the first time in their life or to experience new dimensions of spiritual need. Alternatively, spiritual needs which were a part of the individual's life prior to admission will continue throughout their hospitalisation. It is likely, therefore, that many people will experience spiritual needs when they become patients. Whether or not these needs are met may determine the speed and extent of their recovery and the level of spiritual well-being and quality of life they experience while in hospital. It is important, therefore, that they receive the necessary help to meet their spiritual needs.

One way of ensuring that patients' spiritual needs are met is by using the Nursing Process as the mechanism to deliver systematic individualised spiritual care (Kratz 1979, Marriner 1988). This will involve identifying the patient's spiritual needs through conducting a spiritual assessment, planning and implementing the appropriate interventions to meet these needs and evaluating to what extent these interventions have been successful. At the

FIGURE 8  
A PROPOSED CONCEPTUAL FRAMEWORK FOR GIVING SPIRITUAL CARE USING  
THE NURSING PROCESS



outset this seems fairly simple. However, on closer examination it would appear that in order for each stage of the Nursing Process to be enacted, it will be necessary to have the following knowledge:

<u>Stage of Nursing Process</u>	<u>Knowledge required</u>
Assessment	What spiritual needs are. How they can be recognised i.e indicators of spiritual distress.
Planning } Intervention }	What might be appropriate interventions for the meeting of these needs.
Evaluation	What factors would indicate that the needs had been met i.e spiritual well-being indicators.

To ensure continuity, it would be important to document spiritual care in the patient's care plan. Each stage of the Nursing Process applied to spiritual care is addressed in turn.

#### 1 Assessment

Chapter 1 highlighted the absence of a generally agreed definition of "spiritual" or "spiritual need". This makes it difficult to conduct an assessment. In recent years, however, moves have been made toward developing spiritual assessment tools.



Stoll (1979), in her "Guidelines for Spiritual Assessment" identified four areas for assessment. These included the patient's: 1) concept of God/deity 2) source of hope and strength 3) religious practices and rituals 4) perception of relationship between spiritual beliefs and state of health.

Questions she suggested as useful in exploring the above include:

- o Is religion or God significant for you?
- o To whom do you turn when you need help?
- o Do you feel your faith (religion) is helpful to you? If yes tell me how?
- o Has being sick (or what happened to you) made any difference in your feeling about God or the practise of your faith?

She advocates that the spiritual assessment be placed at the end of the general assessment.

Also, in 1973 Fish and Williams (in Hitchens 1988) developed tools with similar questions and in 1984 Still devised a version for use with children (in Hitchens 1988).

In addition to the development of spiritual assessment tools by nurses, another major area of expansion has been the introduction of the concept of nursing diagnosis. The notion was developed from Henderson's fourteen basic needs and is defined by Carpenito (in Hitchens 1988, p29) as:

"..a statement that describes a health state or an actual or potential alteration in one's life processes (physiological, psychological, socio-cultural, developmental and spiritual)."

Since its inception in 1973, NANDA has developed more than 60 diagnostic categories, one of which is spiritual distress (distress of the human spirit) (Kim et al 1984, p57). This has been defined as:

"..a disruption in the life principle that pervades a person's entire being and that integrates and transcends one's biologic and psychosocial nature."

The diagnosis can be made in relation to the individual's need for forgiveness, love, hope, trust, meaning and purpose and for each need a list of indicators is given (Appendix 1).

Spiritual distress indicators were also used by Highfield and Cason (1983) in relation to the needs: for meaning and purpose; to give and receive love; for hope and creativity and were developed from Clinebell's "religious-existential" framework.

These are also listed in Appendix 1. The concept of spiritual distress is termed "spiritual problems" by Highfield and Cason (1983).

It would appear, therefore, that some developments have been made in the realm of assessing patients' spiritual needs, although as far as the researcher is aware, measures have not yet been employed to test these for validity and reliability.

## 2 Planning and Intervention

Whereas few would argue against nurses assessing patients' spiritual needs and evaluating the care given, disparity appears to exist with regard to whether or not all nurses should be actively involved in responding to patients' spiritual needs.

It is the opinion of most authors that nurses should respond to patients' spiritual needs (Fish and Shelly 1978, Piles 1986). However, De Young (in Hitchens 1988, p43) is doubtful about this and perhaps reflects the opinions of other nurses in her statement:

"I am not convinced the nursing profession should assume the role of meeting patients' spiritual needs. Christian nurses...and perhaps other nurses interested in spiritual matters do have a role in spiritual care. But the fact that some nurses choose to provide spiritual care does not mean that all nurses should".

De Young, however, agrees that all nurses should assess spiritual needs but may refer them elsewhere to be met. As shown in Chapter 1 there are few guidelines to indicate what might be appropriate and inappropriate interventions for meeting patients' spiritual needs.

### 3 Evaluation

Little is known about factors which would indicate that a patient's spiritual needs had been met. Highfield and Cason (1983) used some indicators based on Clinebell's work, but again it is not clear if these were tested for validity and reliability (Appendix 1).

Studies conducted both in the UK (O'Neill 1984) and the USA (Hitchens 1988) tend to indicate that spiritual care is not documented in patients' care plans.

In summary, it would appear that there is a lack of knowledge with regard to what spiritual needs are, how spiritual care may be given and how it can be evaluated which makes it difficult for nurses to give it using the framework of the Nursing Process. Further research is clearly required to contribute to the knowledge base which would enable spiritual care to be given in this way. However, even if this knowledge was available, nurses may still be reluctant to give spiritual care as indicated by De

Young's statement above. There is evidence to suggest that a variety of factors may determine the nurse's ability/willingness to give spiritual care. These include:

- o the way in which the nurse defines the spiritual dimension (Highfield and Cason 1983) and the importance she places on spiritual care (Hitchens 1988, Piles 1986)

- o the nurse's perception of: whose responsibility spiritual care is (Hitchens 1988); her ability to meet patients' spiritual needs (Piles 1986); the obstacles preventing her from responding (Piles 1986)

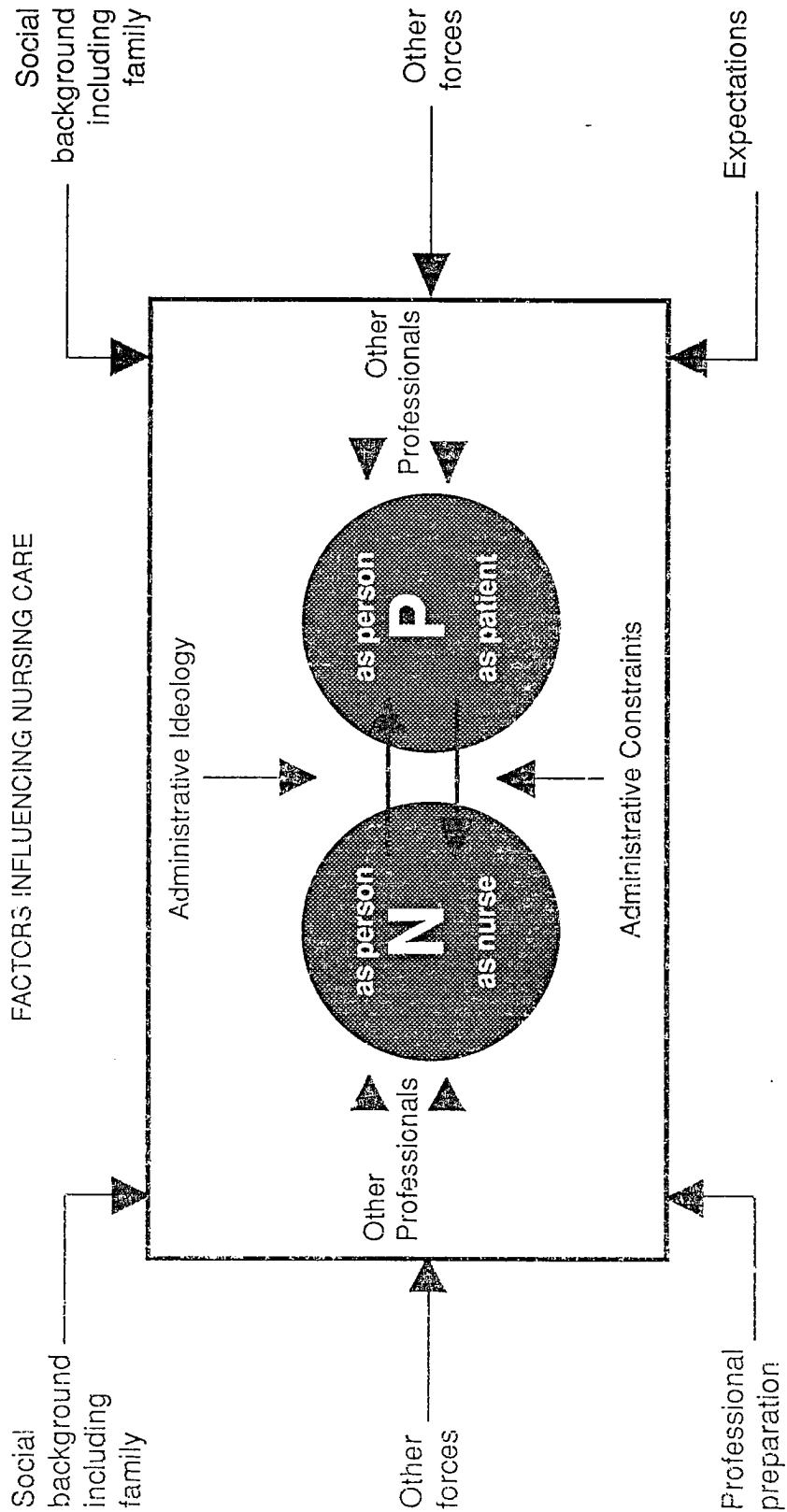
- o the teaching the nurse has received on spiritual care (Hitchens 1988, Piles 1986).

Over-riding all these factors, however, would appear to be the value system of the nurse in determining her ability to give spiritual care. Several authors and researchers cite the degree to which the nurse is aware of, is secure in and has developed her own spiritual quest, as central to her ability to function in giving spiritual care. Many authors have suggested that the nurse's life experience, particularly in the form of crisis, may act as a force for spiritual growth (Granstrom 1985, Hitchens 1988, Kreidler 1984 in Hitchens 1988, Shelly and John 1978, Vailliot 1970).

Thus, most of the above authors and others advocate the teaching of spiritual self awareness to nursing students as a means of educating them on spiritual care. All of these authors were American. No comparable British work was identified. However, in her study of a sample of district nurses in Britain, Hockey (1979) discovered that the care these nurses gave was not entirely dictated by patients' needs but by a variety of other factors, such as personal characteristics of the nurse, her social background and professional preparation as well as work-related factors such as administrative concerns and the influence of other professionals (Figure 9). Although not directly related to spiritual care, the finding is similar to that cited by previous American authors where personal characteristics of the nurse and her professional preparation influenced the care she gave.

In summary, it was noted that guidelines to enable nurses to give spiritual care were lacking. This chapter has suggested a conceptual framework for the giving of spiritual care using the Nursing Process. It is acknowledged, however, that further research is required to produce the necessary knowledge for this framework to become operational and even then, that the ability/willingness of the nurse to give spiritual care might be determined by other factors.

**FIGURE 9**  
**CONCEPTUAL MODEL OF FACTORS**  
**INFLUENCING NURSING CARE**  
**(Hockey, 1979)**



## CHAPTER 3

### OVERVIEW OF THE STUDY



This brief chapter outlines the purpose of the study, details how the population was selected and gives an overview of the general approach adopted for conducting the study.

## 1 PURPOSE

Having reviewed the literature, it is evident that spiritual care is part of the nurse's role (Chapter 1). Little British research on spiritual care and few guidelines for its practice were, however, identified (Chapter 2). Given the importance of spiritual well-being to the attainment of an optimum state of health, together with the fact that the extent to which a patient achieves this will be determined by the nursing care given, it was considered important to gain some insight into how nurses perceive spiritual care and their role in this. Furthermore, the literature review highlighted that a variety of factors may influence how nurses give spiritual care (Chapters 1 and 2). This exploratory, descriptive study sought, therefore, to address the following research questions:

- 1     How do nurses perceive spiritual need and spiritual care and report to give the latter in practice?
  
- 2     What factors appear to influence the spiritual care given to patients?

## 2 SELECTION OF THE POPULATION

The population of nurses intended for inclusion in the study consisted of Staff Nurses (S/N's) and Charge Nurses (C/N's) working full-time day or night duty on non-psychiatric care of the elderly wards situated within general and geriatric NHS hospitals in Scotland. The rationale for each criterion is given below.

### 1 S/N's and C/N's

To minimise the effects that differing levels of qualification could have had on the results (as would have been the case had Enrolled or Student Nurses been included), only those nurses who had achieved a first level qualification in nursing (RGN or SRN) were included.

### 2 Working full-time day or night duty

As nothing was known about the prevalence of spiritual needs only "full-time" staff were included in an attempt to ensure that all nurses had equal opportunity to identify these needs. In addition, as it was thought that spiritual needs may be more evident at night, both day and night staff were included.

### 3 Employed on non-psychiatric care of the elderly wards

Care of the elderly settings were chosen as it was thought that spiritual needs may be easier to identify if nurses had had opportunity to get to know their patients. Psychogeriatric wards were excluded as it was suspected that the condition of such patients might make the identification of spiritual needs difficult.

### 4 Working in general and geriatric NHS hospitals

The above hospitals were selected to minimise the possible influence that special resources/training (e.g hospice care specifically designed to meet the needs of the dying or special facilities provided by private hospitals/homes) might have had on the findings. In order to ascertain if there was any difference in the spiritual care given in general and geriatric hospitals, both were included for comparison.

### 5 Hospitals situated in Scotland

Scotland was chosen for the following reasons:

- o it provided an already existing natural division within the UK
- o a manageable size of population could be obtained

- o by including all Health Boards, any geographical differences found in nurses' perceptions/giving of spiritual care could be detected
- o any differences in culture, nursing administration and nurse training between Scotland and England (Scotland having its own National Board), which may have affected results and made the procedure for gaining access more complicated, could be minimised.

### 3 APPROACH ADOPTED FOR THE STUDY

In order to address the research questions, a blend of both quantitative and qualitative approaches was adopted. Chalmers (1989, p37) states:

"because the strengths of one methodology are often the weaknesses of the other, research that seeks to draw on the strengths of each may maximise the reliability and validity of the results."

It was considered that by using more than one method to collect and interpret data a more accurate representation of how spiritual care was actually perceived and practised by nurses and the factors influencing this care would be obtained. Thus the study was undertaken in two separate but related parts.

In Part 1 (quantitative) a purpose designed postal questionnaire was selected as the method which would elicit basic information from a large number of nurses distributed over a wide geographical area in relation to their perceptions and giving of spiritual care. In Part 2 (qualitative), it was considered that a semi-structured interview would allow for deeper exploration of nurses' perceptions and practice of spiritual care and would create the opportunity for further investigation of factors thought to influence how spiritual care was given. Chapters 4 and 5 describe Parts 1 and 2 respectively.

## CHAPTER 4

### QUANTITATIVE APPROACH

This chapter describes Part 1 of the study namely the quantitative approach. First, the research questions are outlined and the method selected for addressing them is described. The results are then presented, discussed and summarised.

## 1 AIMS

The quantitative part of the study sought to answer the following research question:

1 How do nurses perceive spiritual need and spiritual care and profess to give it in practice? This question was addressed by posing a number of sub-questions which guided the tool design. These are outlined below:

- o What do nurses understand by spiritual needs?
- o What do nurses understand by spiritual care?
- o Do nurses identify patients' spiritual needs?
- o How do nurses identify patients' spiritual needs?
- o How do nurses respond to patients' spiritual needs?
- o How do nurses evaluate the interventions employed to help patients meet their spiritual needs?

## 2 METHOD

### 2.1 METHOD AND RATIONALE FOR ITS SELECTION

Recognising that every method has its strengths and weaknesses it was important to select the one most appropriate to the research questions. In this case a purpose designed postal questionnaire was chosen. The limitations of this method were acknowledged (Hoinville et al 1978, Oppenheim 1966, Polit and Hungler 1987) and a variety of measures employed to minimise their effects as outlined in Table 1.

Despite these limitations, this method was considered the most appropriate for collecting data relevant to the research questions for the following reasons:

- 1 As nothing was known about how nurses perceived spiritual care it was considered important, initially, to gather this information from as many nurses as possible. As the population was distributed over a wide geographical area, the postal questionnaire was the only practical method available.

- 2 It was felt that more honest answers might be obtained as a consequence of respondents feeling less inhibited than may have been the case had an interviewer been present.



**TABLE 1**  
**LIMITATIONS OF THE POSTAL QUESTIONNAIRE AND MEASURES EMPLOYED TO**  
**MINIMISE THEM**

<u>Limitation</u>	<u>Measure(s) employed to minimise/overcome it</u>
1 The response rate achieved from questionnaires is usually lower than that of interviews	o the questionnaire and cover letter were designed in order to maximise the response rate, using recommendations given in the literature
2 The researcher was totally dependent on the ability of respondents to interpret the questions correctly and complete the questionnaire according to the given instructions	o the questionnaire was carefully constructed and rigorously tested through the pre-pilots- and the final pilot study. Changes were made in the light of the findings
3 Factors which may have affected the validity of responses could not be controlled e.g one had to trust that the answers given were those of the respondent and not someone else's	o care was taken to ensure that each questionnaire was received by the nurse intended by enclosing it in a sealed envelope stating the nurse's name  o if a nurse could not be traced, nurse managers were asked to return the questionnaire to the researcher  o to encourage the nurse in receipt of the questionnaire to respond personally, the cover letter asked her not to collaborate with any one else while completing it
4 There was no guarantee that the information provided by respondents was a true reflection of their practice	o unfortunately little could be done about this and the researcher had to rely on a measure of honesty
5 There was no guarantee that the information provided by respondents would be interpreted accurately by the researcher	o as people do not always answer questions under the given headings, the researcher sought to interpret the answer to each question in the context of each nurse's entire response

<u>Limitation</u>	<u>Measure(s) employed to minimise/overcome it</u>
5 cont.	<ul style="list-style-type: none"> <li>o these interpretations would be checked with the sample of nurses selected for interview in Part 2 of the study</li> <li>o reliability checks would be employed</li> </ul>
6 The researcher was dependent on the national and internal hospital mailing systems to ensure safe delivery of the questionnaires	<ul style="list-style-type: none"> <li>o although there was no viable way of checking that every questionnaire arrived at its intended destination, every hospital to which questionnaires had been sent was checked to see that at least one return had been received from it. In this way it was hoped that any gross failures in delivery would be highlighted</li> </ul>
7 The information obtained would be more superficial than that achieved using qualitative methods	<ul style="list-style-type: none"> <li>o it was the intention that more in-depth information would be obtained in Part 2 of the study</li> </ul>

3 Because questions were standardised, responses would be free from interviewer bias and data would be relatively easy to process and analyse.

## 2.2 DESIGN OF THE TOOL

Having decided to use a postal questionnaire this, together with a cover letter were designed and subjected to numerous pre-pilot tests before the final version emerged for use in the pilot study (Appendix 2).

One of the major disadvantages of the postal questionnaire, acknowledged in Table 1, was that of poor response. This is often attributed to factors such as the subject under study, the population selected and sponsoring body, over which the researcher has little control, and to the limited means which exist, namely in the form of the cover letter, to encourage subjects to respond (Forcese and Richer 1973). It was important, therefore, to encourage compliance by manipulating those factors under the researcher's control. Thus the questionnaire and cover letter were designed, as described below, on the basis of guidelines taken from a variety of texts (Goode and Hatt 1952, Gordon and Stokes 1989, Moser and Kalton 1971, Polit and Hungler 1987).

### The questionnaire

Six aspects were considered in designing the questionnaire as outlined below.

#### 1 Questions included

Care was taken to include only questions relevant to the study aims. The questionnaire was designed in three parts: A, B and C.

### Part A

Because the literature review highlighted how personal characteristics of the nurse might influence the way in which they gave spiritual care, in order to explore this, Part A together with question 5 in Part B sought demographic information about respondents. Respondents were informed of the reason for obtaining this information.

### Part B

All questions in Part B, with the exception of Q5, were included to determine how nurses perceived spiritual need and spiritual care and how they gave it in practice.

### Part C

Part C was included to ascertain respondents' reasons, unforeseen by the researcher, for not wishing to complete the questionnaire and therefore to highlight possible characteristics of the non-respondent group.

## 2 Question wording and order

Ambiguities and leading questions were avoided, abstract questions kept to a minimum and questions ordered logically, starting with the least threatening.

### 3 Question type

Open, as well as closed questions were included to obtain more detailed information from respondents. Adequate space was provided for answers.

### 4 Question content

In closed questions categories were mutually exclusive, the "other" option was included and space for additional comments was provided.

### 5 Appearance

Care was taken in the lay-out of the questionnaire e.g spacing, type set. Additionally, as the literature suggested that colour of paper may have a bearing on the response rate, a mini-pilot study was conducted to ascertain the preferred colours i.e green and cream, both of which were used.

### 6 Practicalities

Pre-paid envelopes were included and the study was launched before the summer holiday period.

### The cover letter

Care was taken to ensure that the cover letter performed the following functions:

- 1 provided respondents with information in relation to: the researcher; the subject and purpose of the enquiry; measures taken to ensure confidentiality; instructions for participation
- 2 encouraged nurses to respond by thanking them in advance and stressing the importance of their participation
- 3 gave credibility to the study by using a letter head and obtaining the support and approval of both the Head of Department where the researcher was based (by enclosing her signature) and the relevant authorities within the respondents' Health Authority/Board.

In an attempt to further increase the response rate, all letters were signed individually (Anderson 1970 in Gordon and Stokes 1989) and kept as informal and short as possible.

### 2.3 THE PILOT STUDY

Having designed the tool and carried out a number of pre-pilot tests, it was necessary to conduct a pilot study before launching the main study. This section outlines the reasons for doing so, the method used, the outcome and recommendations for change in the main study on the basis of the pilot work.

#### 2.3.1 Purpose

The functions of the pilot study were to:

- 1 test the questions contained within the questionnaire for ambiguities and ensure that they obtained the desired information
- 2 test the research method so that actual/potential problems could be identified and remedied before launching the main study
- 3 obtain some indication of: the length of time required for respondents to complete the questionnaire so that participants in the main study could be advised of this in advance
- 4 obtain an indication of the likely response rate for the main study.

### 2.3.2 Method

#### Selection of area and population

Care was taken to ensure that the setting of and population for inclusion in the pilot study reflected that of the main study as closely as possible. Because it was intended to include every Health Board in Scotland in the main study, S/N's and C/N's for the pilot study were selected from a Health Authority in the north of England which contained "care of the elderly" wards both within general and geriatric NHS hospitals.

#### Process for conducting the pilot study

Hospitals containing "care of the elderly" wards within the chosen Health Authority were identified (Chaplin 1989). Permission to conduct the pilot study was sought from the appropriate authority and nurse managers were contacted to obtain their co-operation and the names of nurses for inclusion in the pilot study.

Questionnaires were sent, in individually labelled envelopes, to the nurse managers for distribution to the total population of nurses (n=15). Nurses were asked to return their completed forms to the researcher, within two weeks, using the pre-paid envelopes provided. As it was generally agreed in the literature that some form of reminder is usually required to boost the response rate (Goode and Hatt 1952, Forcese and Richer 1973, Kane 1985, Polit



and Hungler 1987), a combined letter of thanks and reminder was sent to all nurses (to maintain confidentiality), via the nurse managers, three weeks after the initial mailing.

On receipt of the questionnaires, data were processed and analysed with the help of SPSS. Part of the analysis involved categorising responses to open questions. Because this gave rise to the possibility of researcher bias, a reliability check was carried out by comparing the categories produced by the researcher with those reached by two independent people who had been provided with the raw data. One person was a final year degree nursing student who had a particular interest in the subject under study and the other was a Chartered Accountant who had no connections with nursing.

The categories produced by both people were very similar to those of the researcher. Minor differences were noted in relation to the number of categories produced rather than the content. Thus from the small number of people who participated in the reliability check for the pilot study, researcher bias was not obvious. The categories are outlined in Table 3.

#### 2.3.3 Outcome

The response rate to and the results of the pilot study are presented and briefly discussed.

### Response rate

The response rate is shown in Table 2 below:

<u>TABLE 2</u> <u>RESPONSE RATE OF THE PILOT STUDY</u>		
	<u>No.</u>	<u>%</u>
Total questionnaires sent out	15	100.0
Returns from initial mailing, before posting out of the reminder letter	4	26.7
Returns received following the mailing of the reminder letter	1	6.7
Total completed questionnaires received	5	33.3
Questionnaires returned uncompleted from nurse managers because respondent had left employment	1	6.7
Questionnaires not returned	9	60.0

The 33.3% (n=5) response rate was disappointing and less than satisfactory. The fact that nine out of fourteen nurses did not reply, even with the use of a reminder letter, was a matter for concern. One possible explanation was that subjects had been invited to participate in the pilot rather than the main study.

It appeared, therefore, that additional measures would be required to increase the response rate in the main study as discussed later in the chapter.

### Results and discussion

The results of the pilot study are presented in Table 3. Because of the small numbers involved, percentages have been omitted.

**TABLE 3**  
**RESULTS OF THE PILOT STUDY**

<b>PART A OF THE QUESTIONNAIRE</b>	
<b>Grade</b>	<b>No. of nurses</b>
Charge Nurse	5
Staff Nurse	0
<b>Sex</b>	
Female	5
Male	0
<b>Age</b>	
< 21 years	0
21-29 years	0
30-39 years	1
40-49 " "	2
50-59 " "	2
60> years	0
<b>Length of time in practice</b>	
Less than 1 year	0
1-5 years	0
6-10 years	0
11-25 years	2
26 years and over	3
<b>Type of ward</b>	
Long term care	2
Geriatric rehabilitation	1
Combined long term care + geriatric rehabilitation	1
Combined long term care, geriatric rehabilitation + accident & emergency	1
<b>Type of duty</b>	
Day duty	4
Night duty	1
Rotation of day and night duty	0
<b>PART B OF THE QUESTIONNAIRE</b>	
<b>Nurses' definitions of spiritual need</b>	
1 Need for/of religion including: - need to practise religious beliefs - need to turn/return to religious commitment	1

	No. of nurses
2 Need of the 'soul'	1
3 Need to talk to church member/nurse about individual needs	1
4 Need for/of religion + Need to feel that beliefs are respected	1
5 Needs of the 'inner self' + need for belief in something/someone	1
<b>Nurses' definitions of spiritual care</b>	
1 Take account of patients' beliefs/religious beliefs and help them with their customs whatever these may be	3
2 As in 1 above + Give the patient 'peace of mind'	1
Did not answer the question	1
<b>Person nurses' stated they considered to be responsible for responding to patients' spiritual needs</b>	
1 Nurse alone	0
2 Nurse + clergy	4
3 Clergy alone	0
4 No-one	0
5 Anyone who can help	1
<b>Nurses' statements of whether or not they had identified a spiritual need</b>	
1 Yes	4
2 No	1
<b>Indicators nurses stated they used in recognising spiritual needs</b>	
1 Patient's fear of death	1
2 Unresponsiveness of patient	1
3 Patient appeared distraught + afraid of death	1
4 Patient talked about his/her faith	1
Did not answer the question	1

No. of nurses	
<b>Nurses' stated responses to patients' spiritual needs</b>	
1 Talked with patient about their situation. Suggested contact/contacted clergy	3
2 Contacted member of family to find out patient's religious needs	1
Did not answer the question	1
<b>Nurses' evaluations of the effectiveness of responses made to patients' spiritual needs</b>	
1 Totally effective	1
2 More effective than ineffective	2
3 Don't know	1
4 More ineffective than effective	0
5 Totally ineffective	0
Did not answer the question	1
<b>Factors nurses stated they used in evaluating the effectiveness of their interventions</b>	
1 Patient was more calm + returned to their "old self"	1
2 Patient was pleased to see clergy	1
3 Complete/partial reduction of fear + Acceptance of death indicated by ability to calmly and openly talk about it with staff and family	1
Did not answer the question	2
<b>Nurses' statements of whether or not they would have responded any differently to patients' spiritual needs</b>	
1 Yes	0
2 No	4
Did not answer the question	1

No. of nurses	
<b>Ways in which nurses stated they would have responded differently</b>	
Did not answer the question	5
<b>Profession of religious affiliation</b>	
Yes	5
No	0
<b>Type of religious affiliation claimed</b>	
Church of England	4
Roman Catholic	1
<b>PART C OF THE QUESTIONNAIRE</b>	
<b>Reasons given for not completing the questionnaire</b>	
Did not answer the question	5

Little could be concluded from the results, given that only five usable questionnaires were returned. It is noteworthy, however, that all of those responding were C/N's with considerable experience, claiming some form of religious affiliation.

It seemed that nurses tended to view spiritual need in religious terms and considered spiritual care to involve responding to these needs through formal religious means. Four of the five nurses said they had identified a spiritual need at some point in their practice, whether through some form of distress displayed by the patient or because the patient conveyed this verbally.

All five nurses considered it their duty to respond to patients' spiritual needs. Three of the four nurses who had identified a spiritual need responded by discussing this with the patient and then referring/suggesting referral to the clergy. One collaborated with the patient's family.

Three of the four nurses considered their action to have been effective because of eustressing (opposite of distress) characteristics observed in the patient. One was unsure of how effective her intervention had been.

#### 2.3.4 Changes in the main study on the basis of the pilot study

No ambiguities were identified in the questions included in the questionnaire and the information sought was obtained.

Concerning the method, only minor alterations were made. Quotations from the Codes of Conduct were removed from the cover letter because some nurses responded using phrases similar to those quoted therein. Also the code numbers were transferred from the text to columns at the side of the questionnaire because the layout appeared to cause confusion.

Respondents in the pilot study indicated that they had taken 10-20 minutes to complete the questionnaire. This information was, therefore, included in the cover letter for the main study.

As previously discussed, additional measures would be required to boost the response rate in the main study. Having made the above amendments, the cover letter and questionnaire for the main study were finalised (Appendix 3).



#### 2.4 OPERATIONALISATION OF THE QUANTITATIVE APPROACH

Having completed the pilot study and made the necessary alterations, the main study was launched and conducted in accordance with the process outlined in Figure 10.

All letters referred to are shown in Appendix 4.

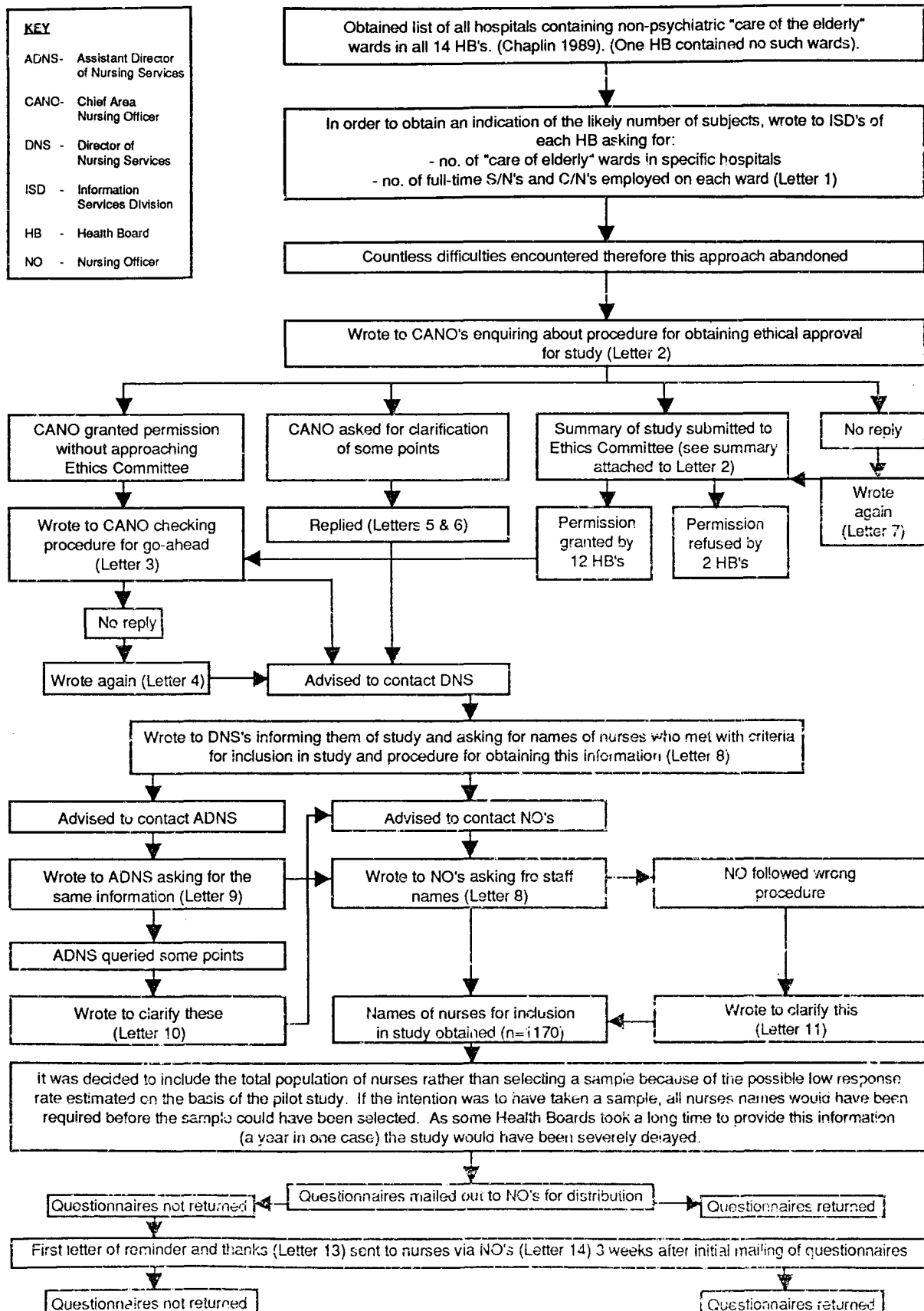
#### 2.5 RESPONSE RATE AND PROBLEM OF NON-RESPONSE

Having conducted the study according to the process outlined in Figure 10, 637 questionnaires (54.4%) were returned of which 529 (45.2%) were usable as illustrated in Table 4.

TABLE 4  
INITIAL RESPONSE RATE TO THE MAIN STUDY

	<u>No.</u>	<u>%</u>
Total questionnaires sent out	1170	100.0
Questionnaires returned from initial mailing before posting out of Reminder Letter 1	372	31.8
Questionnaires returned following mailing of Reminder Letter 1	157	13.4
Questionnaires returned but unusable because respondents did not meet with criteria for the study	34	2.9
Questionnaires returned uncompleted from nurse managers	74	6.3
Total questionnaires returned	637	54.4
Usable questionnaires	529	45.2
Questionnaires not returned	533	45.6

**FIGURE 10**  
**OPERATIONALISATION OF THE QUANTITATIVE APPROACH**



The response rate of 54.4% achieved in the main study was higher than that expected (i.e 30-35% from the pilot study). This may have been because respondents valued participation in the main study more highly than the pilot study. The necessity of employing additional measures to increase the response rate, as recommended by the pilot study, was therefore questioned and the literature was reviewed to see what was an acceptable response rate. Response rates from as low as 0% (Ferber 1948 in Robin 1973) to as high as over 90% (Moser and Kalton 1971) were reported. However, there appeared to be a consensus of opinion that a 40-60% response rate was "good" (Bailey 1978 in Kane 1985, Oppenheim 1966, Orenstein and Phillips 1978, Warwick and Lininger 1975) with that in excess of 75% being exceptional (Goode and Hatt 1952 in Robin 1973, Oppenheim 1966, Warwick and Lininger 1975).

According to the literature, therefore, the 54.4% response rate achieved in this study was acceptable. However, this still meant that almost half (45.6%) of the nurses had failed to respond. The researcher was concerned that those who had responded perhaps held different views on the subject under study from those who had not responded and were, therefore, unrepresentative of the total population of nurses (Robin 1973, Youngman 1978). For instance it was suspected that some nurses may not have responded due to lack of time or interest in the subject (Moser and Kalton

1971) especially if they held more neutral opinions on spiritual care (Boek and Laid 1963, Katz and Cantril 1937, Franzen and Lazarsfeld 1945 all in Champion and Sear 1973).

As Oppenheim (1966, p34) states:

"Non-response is not a random process, but has its own determinants".

In spite of the literature, therefore, in order to minimise the effects of possible non-respondent bias, it was decided to employ measures to increase the response rate further by sending a second reminder letter and copy of the questionnaire to the non-respondent group (Forcese and Richer 1973, Moser and Kalton 1971, Youngman 1978).

Before this was done, however, some assurance that such an intervention would be economically viable was sought.

Using the rough guideline that:

"..something like the same proportion of persons sent questionnaires respond to each mailing" (Moser and Kalton 1971, p266)

it was estimated that, of the non-respondent group (n=533), 31.8% (Table 4) would respond to the second mailing resulting in an additional 170 questionnaires being received. This would increase the overall response rate by 14.5%.

Using the above estimate, it was decided to check the effectiveness of the second mailing by sending a second reminder letter and questionnaire (Appendix 4) to non-respondents in one randomly selected Health Board. As the response rate was higher (42%) than expected (33.4%), this procedure was repeated in all other Health Boards. In total, 156 additional questionnaires were received raising the overall response rate of the study by 13.3% to 67.8% as shown in Table 5.

TABLE 5  
RESPONSE RATE TO THE MAIN STUDY

	<u>No.</u>	<u>%</u>
Questionnaires returned following mailing of the second reminder letter and second copy of the questionnaire	156	13.3
Total questionnaires returned	793	67.8
Total usable questionnaires	685	58.5
Total questionnaires not returned	377	32.2

## 2.6 DATA PROCESSING

As both closed and open questions were included in the questionnaire, responses to each required a different method of processing. Both of these methods, together with details of a reliability check employed, are described in this section.

### 2.6.1 Processing of responses to closed questions

Closed questions included:

- all questions in Part A of the questionnaire
- questions 3,4.1, 4.4a, 4.5, 5 in Part B.

Responses to these questions were processed as described below.

All responses were allocated code numbers which were inserted in the "CODE" column of the questionnaire.

Responses to questions containing the "other" option, (i.e Part A question 4 and Part B questions 3 and 5b), were allocated to categories which emerged directly from the data. These are outlined in Figures 18, 22 and Table 9. The appropriate code numbers were then entered in the "CODE" column of the questionnaires.

All codes were entered into the SPSS data file.

### 2.6.2 Processing of responses to open questions

Open questions included:

- questions 1, 2, 4.2, 4.3, 4.4b, 4.6 in Part B of the questionnaire
- Part C.

The "Ethnograph" package was used to assist in the processing of responses to open questions. This package was developed by American social scientists (Seidel et al 1988) who were involved in qualitative research and was designed to assist with the analysis of text based data. It enables the researcher to code, recode and sort data into categories. Sections of text can then be displayed, sorted and printed in any order. It is important to note that the programme only acts as a mechanical aid. It does not take over any of the thinking aspects of the analysis. Rather, by performing the time consuming tasks of "cutting and pasting", which was previously a laborious part of a qualitative researcher's work, it releases the researcher to devote time to the more crucial interpretive analysis. In this way the Ethnograph proved invaluable to the researcher in managing data relevant to open questions.

Responses to each open question were assigned to categories which emerged from the data. New categories were created only when responses could not be classified under previously established categories. Because questions 2 and 4.3 in Part B of the questionnaire seemed to elicit similar information, they were combined and treated as a single question.

Initially the number of categories per question was very large e.g 70 for one question, therefore all categories were collapsed and are listed in Appendix 5.

Given the large number of categories still existing, some of which contained few responses, it was decided to merge categories where common themes existed.

In doing so it was found that many new categories were similar to those identified in the literature. To detect researcher bias in the collapse of categories, the process by which this had occurred was checked independently by the project supervisors who were generally in agreement with the alterations made. The process is described below.



### Merging of categories

The way in which the categories relevant to each question in Part B and C of the questionnaire were merged is described in turn. Where similar categories had been identified in the literature, the relevant authors are stated.

#### Q1 How would you define the term "spiritual need"?

Six new categories were produced from the original fifteen. These were:

##### 1 Need for meaning, purpose and fulfilment.

(Category similar to that identified by: Chomicz 1984, Conrad 1985, Fish and Shelly 1978, Highfield and Casen 1983, Renetzky 1979, Simsen 1985, Stallwood-Hess 1969).

Collapsed under this category were: (numbers correspond to those in Appendix 5)

10 "Need to find meaning in life"

because it was directly relevant.

11 "Need to be alone/for reflection".

One of the indicators of the need for meaning and purpose identified by Highfield and Cason (1983) was "exhibits emotional detachment from self and peers". This suggests a desire to be alone. Furthermore the act of reflection is often closely associated with the search for meaning.

13 "Need for a sense of fulfilment/satisfaction".

Another indicator of the need for meaning cited in the study by Highfield and Cason (1983) was "expresses contentment". According to the dictionary (Macdonald 1972), contentment and satisfaction are synonymous. Furthermore Renetzky (1979) classes the need for fulfilment together with the need for meaning and purpose.

2 Need to give and receive love and forgiveness.

(Category similar to that identified by: Chance 1967, Chomicz 1984, Conrad 1985, Fish and Shelly 1978, Highfield and Cason 1983, Jacik 1989, Simsen 1985, Stallwood-Hess 1969).

Collapsed under this category were:

5 "Need for love, unity and forgiveness"

because it was of direct relevance.

14 "Need to talk about/explore issues".

Although this would also have fitted under the "need for meaning, purpose and fulfilment", it was decided to place it here because two of the indicators of the need for love and forgiveness noted by Highfield and Cason (1983) were :

- "does not discuss feelings about dying with significant others"
- "confesses thoughts and feelings about which he is ashamed".

Central to the above statements is talking and exploring.

### 3     Need for hope and creativity.

(Category similar to that identified by: Chance 1967, Chomicz 1984, Conrad 1985, Highfield and Cason 1983, Renetzky 1979, Simsen 1985).

Included in this category were:

- 6 "Need for a sense of elation/joy/exuberance/more of life".

Two of the indicators of the need for hope and creativity mentioned by Highfield and Cason (1983) were "boredom" and "unable to pursue creative outlets". The experience of elation etc seemed to represent the opposite end of the spectrum for these expressions. In addition the need for the will to live, which is similar to the desire for more of life, was a spiritual need identified by Renetzky (1979) and is closely linked with hope.

8 "Need for hope"

because it was directly relevant.

4 Need for belief and faith.

(Category similar to that identified by: Chance 1967, Chomicz 1984, Renetzky 1979, Simsen 1985).

Included in this category was:

4 "Need to believe in something/someone"

because it was obviously connected.

5 Need for peace and comfort.

(Category similar to that identified by Jacik 1989).

Included in this category were:

7 "Need to achieve a state of comfort"

because it was of direct relevance.

12 "Need which appears in crisis and, in particular, on approaching death"

Only when an individual has come to terms with a situation e.g death, can they experience a sense of peace and comfort.

6 Miscellaneous

Included in this category were:

- 1 "A need which is more than: physical; mental; emotional; social"
- 2 "A psychological or emotional need"
- 3 "A deep inner need. A need of the "soul" or core of the person"
- 9 "An individual need which varies from person to person"
- 15 "With difficulty".

None of the above fitted any of the previous five categories or was mentioned often enough to warrant a separate category.

Q2            How would you define the term "spiritual care"?

Q4.3        What did you do in response to this need?

1        Recognising/respecting/meeting patients spiritual needs.

(Category similar to that identified by Stallwood-Hess 1969).

Included in this category were:

- 1a "Recognising/respecting/meeting patients' spiritual needs"

because it obviously fits.

- 7 "Did nothing. Respected patient's wishes for no action to be taken"

because by taking no action the nurse was showing respect.

- 12 "Finding out more about patients' beliefs".

It was assumed that the nurse was attempting to find out more about the patient's beliefs so that care could be given to the patient in a manner which was in keeping with those beliefs.

- 13 "Documenting 'Nursing Process' records".

In doing this it was assumed that the nurse was ensuring continuity of care in keeping with their beliefs.

2 Facilitating participation in religious rituals.

(Category similar to that identified by: Carson 1989, Chance 1967, Martin et al 1976, Stallwood-Hess 1969).

Included was:

- 1b "Enabling patients to meet their spiritual needs"

because all activities to which this statement refers were concerned with helping patients perform religious acts.

3 Communicating: listening; talking with.

(Category similar to that identified by: Carson 1989, Chance 1967, Martin et al 1976, Stallwood-Hess 1969).

Included were:

2 "Communicating with patients/relatives"

because all the items included under this heading involved talking, exploring, guiding and listening, all of which are modes of communication.

14 "Using humour"

because the essence in which humour was used was in guiding the patient toward reality and acceptance of the situation they were in.

15 "Distracting the patient from the present situation"

for the same reason as given in 14 above.

4 Being with the patient: caring, supporting, showing empathy.

(Category similar to that identified by: Carson 1989, Martin et al 1976).

Included were:

3 "Caring for and supporting the patient/family".

9 "Giving/sharing of self".

10 "Being there".

16 "Supporting the patient".

All of the above clearly corresponded with the category description.

5     Promoting a sense of well-being.

Although this was not a category found in any previous studies it emerged directly from the data and was felt to be significantly different from all other categories to warrant separate attention.

Included were:

4     "Promoting a sense of well-being"

as it was of obvious relevance.

8     "Helping the patient generally"

By generally helping and carrying out patients' requests/wishes the nurse can promote a sense of well-being by making the patient feel worthwhile.

11    "Giving the patient self esteem"

By catering to the patient's esteem needs a sense of well-being can be facilitated.

6     Referring to others

(Category similar to that identified by: Carson 1989, Chance 1967, Martin et al 1976, Stallwood-Hess 1969).



Included was:

6 "Referring to others"

as all items included under this heading involved referral whether directly or indirectly.

7 Expressed difficulty in defining or giving spiritual care.

Included was:

5 "Expressed difficulty in defining or giving spiritual care"

because it obviously fitted.

Q4.2 How did you recognise this need?

The number of categories was reduced from 11 to 6 as outlined below. Few studies addressed the issue of indicators of spiritual need, the main one being that of Chance (1967). Highfield and Cason (1983) cited many indicators of spiritual need but they did not categorise these.

1 The need was expressed by the patient verbally or non-verbally.

Included was:

1 "Through communication"

because the central theme is the patient communicating their need through verbal or non-verbal means. Both modes of communication were mentioned by Chance (1967).

2 The need was observed by the nurse in other ways.

Included were:

2 "Through observation of the patient"

because in all items included the spiritual need was detected through the nurse's observation of the patient.

3 "By knowing the patient"

because it was through knowing/known something about the patient that the need was observed by the nurse.

3 Through distress displayed by the patient.

Included were:

4 "Distress displayed by the patient"

because it was of direct relevance. Chance (1967) also produced two categories namely "emotional attitudes" and "tears" which are similar to some aspects of this category.

5 "Patient was awkward/hostile".

The central theme was that of distress. Many of the characteristics outlined in this category were similarly identified by Highfield and Cason (1983) as indicators of spiritual distress.

9 "Physical signs".

The presence of pain, elevated blood pressure and pulse and failure of physical interventions to alleviate the problem can all either cause distress or indicate that the patient is distressed.

4 Through state of helplessness displayed by the patient.

Included were:

6 "Helplessness".

Seligman's (1975) state of "learned helplessness" seemed to best describe these characteristics identified by nurses as indicative of spiritual need. All involve one or more of the symptoms of this condition namely: passivity; negative cognitive set; lack of aggression; social deficits. The important distinction between this category and that of "Distress" is that of apathy. In the "Distress" category most of the characteristics are active e.g. anger, fear, aggression. Here there are no active states. Many of these characteristics were also identified by Highfield and Cason (1983).

7 "Low self esteem".

Vulnerability and unworthiness are themes alluded to by Seligman (1975) in his writings on learned helplessness.

5 Through patient's desire/inability to come to terms with situation

This category emerged directly from the data and was felt to be significantly different from all other categories to warrant separate attention. Included was:

8 "Expressed desire/inability to come to terms with past/  
present/future"

because it was directly relevant.

6 Positive characteristics displayed by the patient.

All of the previously mentioned categories major on negative characteristics displayed by the patient. It was felt that the positive characteristics patients displayed which enabled nurses to recognise a spiritual need should be grouped together in the form of a separate category. Included were:

10 "Desire for life"

11 "Prepared for death"

both being positive characteristics.

Q4.4b      How effective do you consider this response was?  
What made you think that?

The number of categories was reduced from ten to seven. Most of the indicators nurses stated had enabled them to evaluate the effectiveness of their interventions in meeting patients' spiritual needs were the opposite of those which had led them to identify the need initially. These are described below.

1      Eustressing characteristics displayed by the patient.

Seleye's state of "eustress", being the opposite of distress, seemed to best describe the characteristics mentioned in:

1      " Patient reached a state of eustress".

2      Patient appeared brighter in mood.

All of the characteristics outlined in the following categories opposed the state of helplessness/hopelessness.

2      "Brighter in mood".

4      "Increased/improved relationships with others".

6      "Increased self esteem".

3 Patient's ability to accept situation.

This was the opposite of "Inability to accept situation" mentioned in QB4.2. Included was:

- 3 "Able to accept or displayed signs of working towards acceptance of situation".

4 Patient confirmed that his/her need had been met.

The patient confirmed the above in the same ways that he/she had expressed the need in "Patient expressed the need" in QB4.2 i.e using verbal and non-verbal communication. Included was:

- 5 "Confirmed by the patient in some way".

5 Nurse felt the need was met. Not necessarily confirmed by the patient.

The nurse observed that the need had been met in the same way that she had identified it in QB4.2 "Through observing the patient". The emphasis is on observation and "sensing". Included was:

- 7 "Need had been met".

6     Nurse felt that the need was not met/not completely met.

In some instances, usually when they stated that their interventions had been ineffective, nurses felt that the patient's need had not been met. It was felt that the negative characteristics indicative of this should occupy a separate category. Included were:

8        "Need was not met/not completely met".

9        "Nurse felt inadequate in dealing with the situation".

7     Nurse expressed difficulty in assessing the effectiveness of her interventions

Again it was felt that this group of responses was significantly different from all others to merit occupation of a separate category. Included was:

10       "Nurse did not know/found it difficult to assess the effectiveness of her response".

Q4.6       What would you have done differently?

Given the small number of nurses who answered this question it proved difficult to reduce the categories further. Only two categories were collapsed namely:

3 "Involved others".

6 "Tried to overcome own feeling of inadequacy".

These were merged to form one category:

Involved others/sought help

as it was assumed that in some cases nurses would have involved others because they felt unable or inadequate to deal with the situation.

Because of the small number of nurses who used Section C of the questionnaire, it was not possible to reduce the categories any further, therefore, they remain as listed in Table 16.

2.6.3 Reliability check

Having processed the data relevant to open questions, before they were entered into the SPSS data file for analysis, it was considered important to check that all the intended changes in the various categorisations of responses had been made correctly. Thus a reliability check was conducted on the "Ethnograph" package and the researcher before questionnaires were checked generally for meaning. Each check is described in turn.



### Checking the "Ethnograph" package for reliability

Every tenth intended change in categorisation was checked to make sure it had been made. Out of the 430 checks no errors were found as shown in the working below. (Formulae were obtained from Walsh 1990).

$$\begin{aligned}\% \text{ error} &= \frac{\text{number of errors}}{\text{total checks}} \times \frac{100}{1} \\ &= \frac{0}{430} \times \frac{100}{1} \\ &= 0\end{aligned}$$

As the percentage error was zero, with any size of confidence limit it can be predicted that out of the total number of changes made by the "Ethnograph" package, the % of errors will also be 0.

It was concluded, therefore, that the "Ethnograph" package was a reliable tool.

### checking the reliability of the researcher

It was considered that researcher error would most likely arise from typing mistakes e.g mis-spelling and inadvertent omission of code words. To check for this, for every question, a Health Board was chosen at random and the original codes intended for re-coding were re-typed into the computer. If all code words had been typed properly the first time all changes should have been made, therefore no changes should have occurred on the second typing (assuming that the second typing was correct).

Out of the 246 words re-typed, four typing errors were found. All errors were due to the researcher having failed to type some words rather than having typed the wrong words. All errors would have been detected in the final coding of responses because these particular code words were no longer in existence. The % of error found in the sample of words re-typed was 1.63% as shown in the following working:

$$\begin{aligned}
 \% \text{ error (p)} &= \frac{\text{number of errors}}{\text{total checks}} \times \frac{100}{1} \\
 &= \frac{4}{246} \times \frac{100}{1} \\
 &= 1.63\%
 \end{aligned}$$

Extending this to the total number of words typed, there was a 95% probability that the % of error lay between 0.048% and 3.21% as shown in the following working:

$$\begin{aligned}
 \text{Standard Error (SE) in the sample} &= \sqrt{\frac{p (100 - p)}{N}} & p &= \% \text{ of error in the sample} \\
 & & n &= \text{number in the sample} \\
 &= \sqrt{\frac{1.63 \times (100 - 1.63)}{246}} \\
 &= 0.807\%
 \end{aligned}$$

$$\begin{aligned}
 \text{Using a 95\% confidence interval, the \% error estimated in the total words typed} &= p + 1.96 \times SEp \\
 &= 1.63 + 1.96 \times 0.807 \\
 &= 0.048\% \text{ and } 3.21\%
 \end{aligned}$$

It was concluded that the researcher was reliable in typing accurately. It was assumed, therefore, that the intended code words for change were altered correctly in the majority of instances. Given that the % error in the sample was negligible and that all would have been detected in the final check, it was not considered necessary to conduct a second check on all words typed.

### Checking questionnaires for meaning

As responses had been subjected to considerable re-coding, it was feared that the meaning of some responses may have been lost. Every tenth questionnaire (i.e 63) was, therefore, checked by the researcher only to ensure that the meaning of each response was most appropriately captured by the category to which it had been assigned.

Out of the 468 code words checked from the 63 questionnaires, 68 errors were found. An error was considered to have occurred when a response which had been assigned to a category could, in the opinion of the researcher, have been more appropriately categorised.

The % error in the above sample was 14.53% as shown in the working below:

$$\begin{aligned}\% \text{ error} &= \frac{\text{number of errors}}{\text{total checks}} \times \frac{100}{1} \\ &= \frac{68}{468} \times \frac{100}{1} \\ &= 14.53\%\end{aligned}$$

As the next working illustrates there was a 95% probability that the % of errors in the total number of questionnaires lay between 11.33% and 17.72%:

$$\begin{aligned}
 SE &= \sqrt{\frac{p(100 - p)}{N}} \\
 &= \sqrt{\frac{14.53 \times (100 - 14.53)}{468}} \\
 &= 1.63\%
 \end{aligned}$$

Using a 95% confidence interval the % error =  $p \pm 1.96 \times SEp$   
 $= 14.53 \pm 3.194$   
 $= 11.33\% \text{ and } 17.72\%$

It was felt that this incidence of error was too high, therefore all categorisations of responses in all questionnaires were re-checked for meaning and altered accordingly.

## 2.7 DATA ANALYSIS

Having processed the data, they were analysed as follows.

1 Frequency distributions were conducted within SPSS to obtain demographic information and to ascertain how nurses perceived spiritual need and spiritual care and how they reported to have given it in practice.

2 In order to identify factors which appeared to influence the spiritual care given, a twofold approach was adopted.

First, factors reported by some nurses to have influenced the spiritual care given were noted.

Second, in order to more reliably identify factors which may have influenced the spiritual care given, variables were cross-tabulated in SPSS.

Cross-tabulation made it possible to establish if associations existed between variables and, if so, the probability that these associations could have occurred by chance. It was, however, not possible to determine the direction of the association or to prove cause and effect (Norusis 1988, Reid and Boore 1987).

The following section reports the results of these analyses.

### 3 PRESENTATION AND DISCUSSION OF RESULTS

Having processed and analysed the data as outlined, the results are described and discussed in three sections. First the demographic data are presented. Second, nurses' perceptions of spiritual need and spiritual care and their reports of how they gave this are described and finally attention focuses on factors which appeared to be associated with the giving of spiritual care.

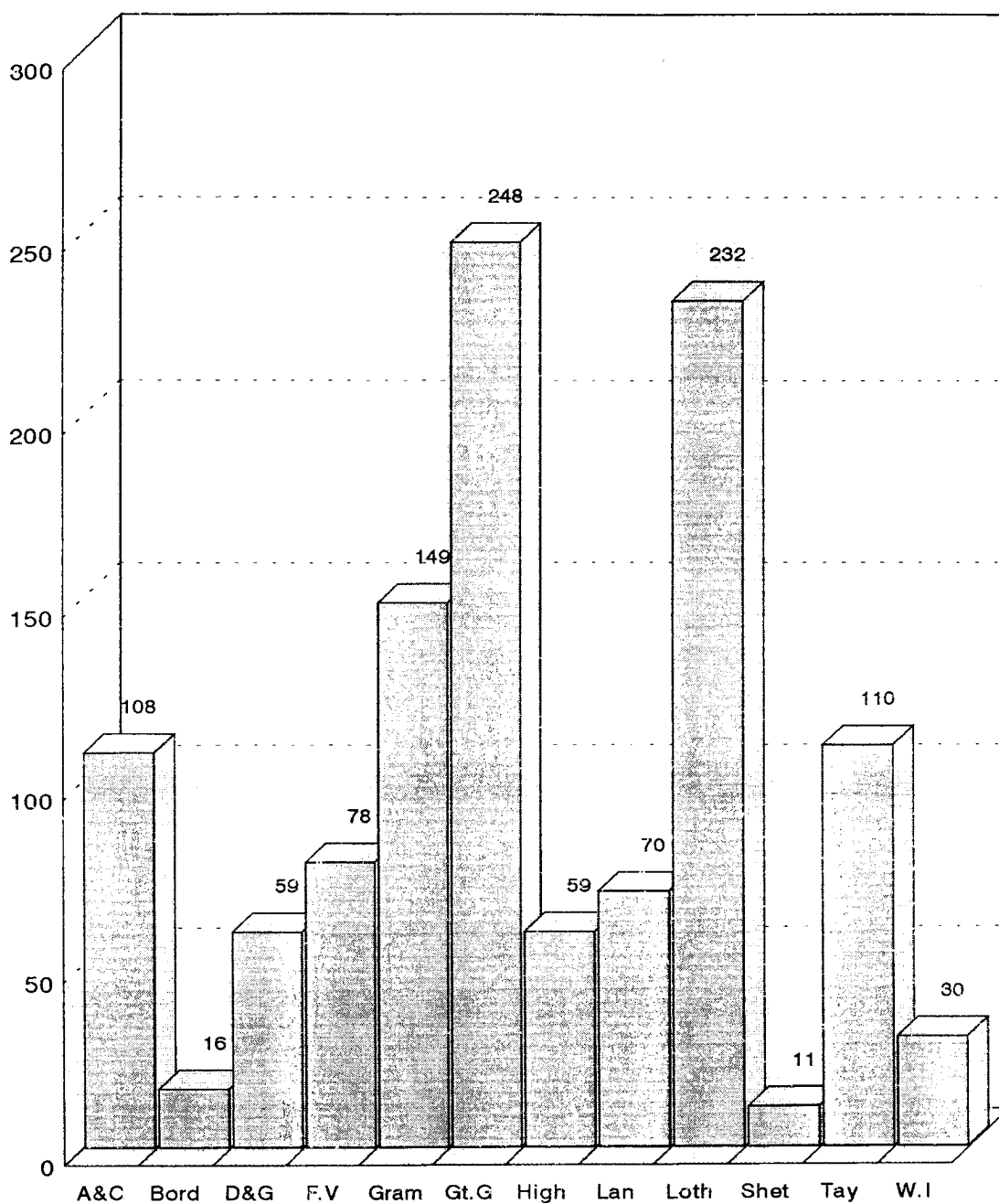
#### 3.1 DEMOGRAPHIC INFORMATION ABOUT RESPONDENTS

The demographic data, obtained from Part A and Part B Q5 of the questionnaire, are presented in a series of figures and the main points are highlighted. The following key outlines the abbreviations used for Health Boards.

#### Key for Health Boards

A&C - Argyll & Clyde	High - Highland
Bord - Borders	Lan - Lanarkshire
D&G - Dumfries & Galloway	Loth - Lothian
F.V - Forth Valley	Shet - Shetland
Gram - Grampian	Tay - Tayside
Gt.G - Greater Glasgow	W.I - Western Isles

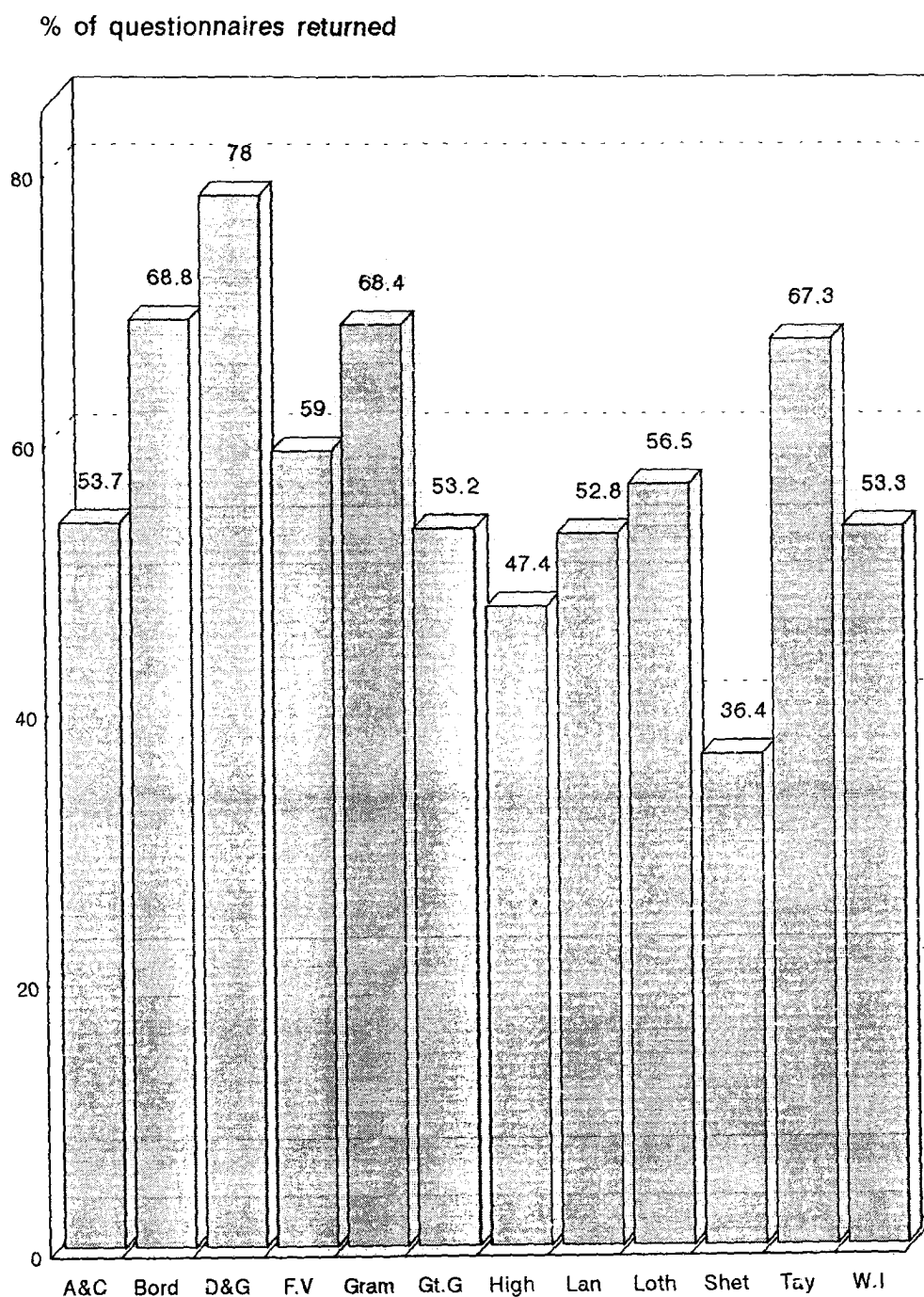
**FIGURE 11**  
**NUMBER OF QUESTIONNAIRES DISTRIBUTED TO EACH HEALTH BOARD**



As Figure 11 shows, the number of questionnaires distributed to Health Boards was roughly in proportion to their size in terms of population.



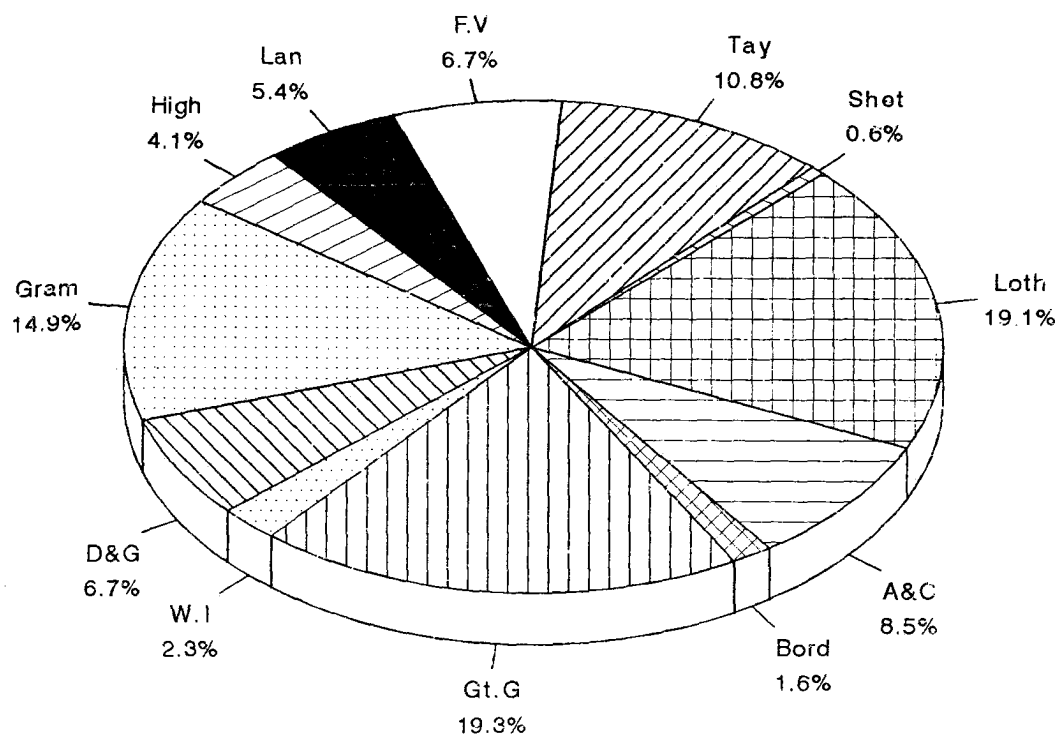
**FIGURE 12**  
**RESPONSE RATE FROM EACH HEALTH BOARD**



The highest response rates were obtained from Dumfries and Galloway, Borders and Grampian (in descending order) and the lowest from Shetland, Highland and Lanarkshire (in ascending order). No clear explanation for this finding could be identified.

**FIGURE 13**  
**DISTRIBUTION OF RESPONDENTS ACCORDING TO HEALTH BOARD AREA**

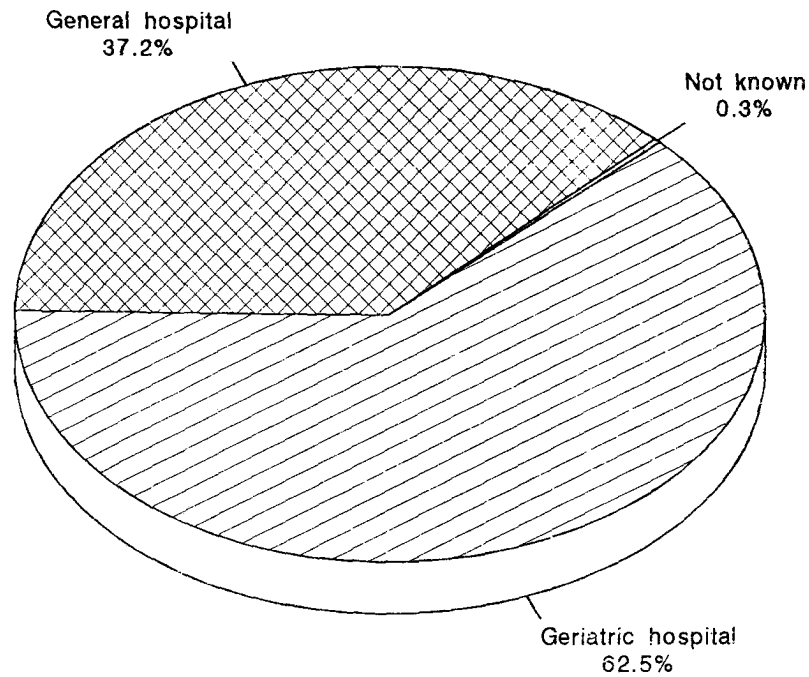
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The distribution of respondents was roughly in proportion to Health Board size in terms of population.

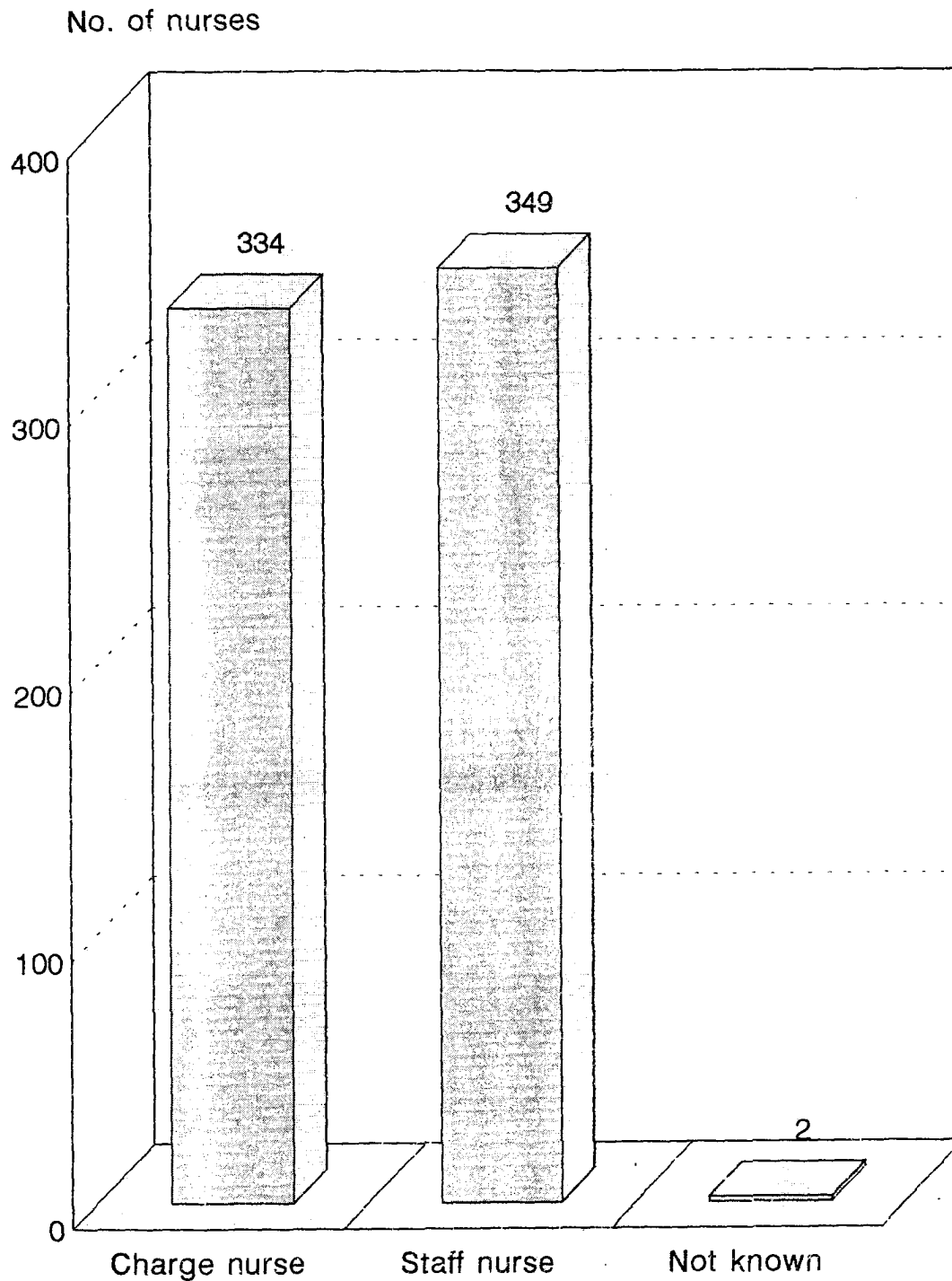
**FIGURE 14**

**DISTRIBUTION OF RESPONDENTS ACCORDING TO HOSPITAL TYPE**



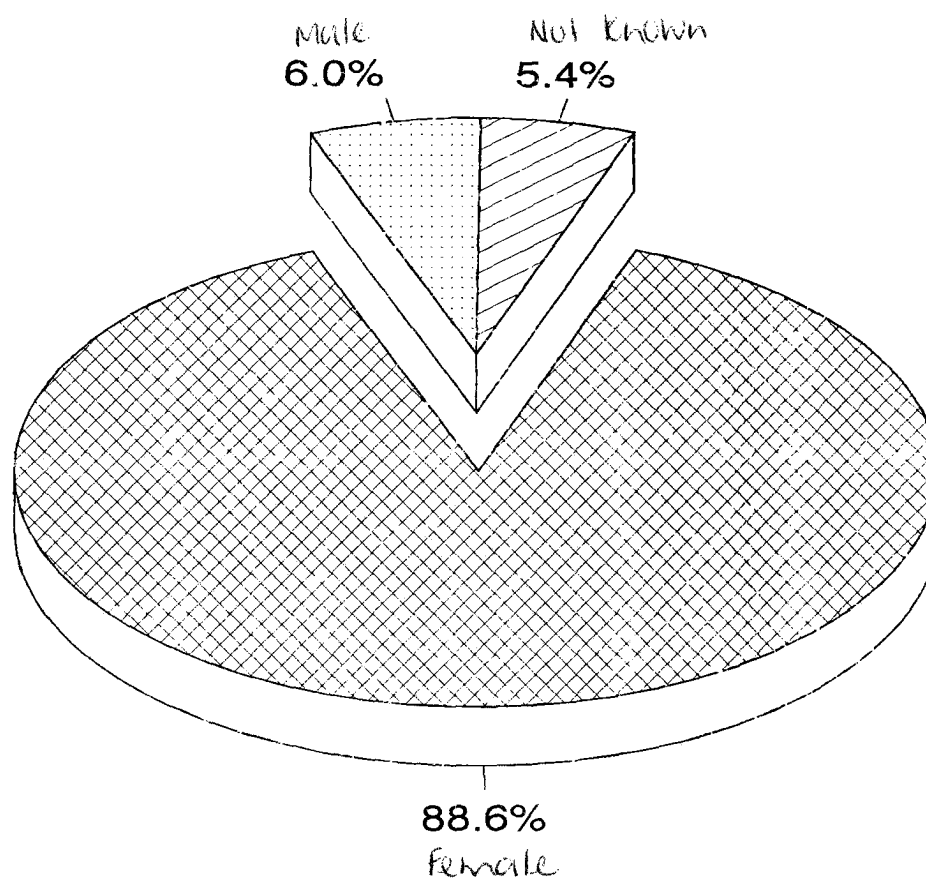
The majority of respondents were working in geriatric hospitals which was a reflection of the population distribution according to hospital type. In two cases it was not known what type of hospital the nurses were working in as a nurse manager had photocopied questionnaires for these nurses thus the coding was lost.

**FIGURE 15**  
**GRADE OF RESPONDENTS**



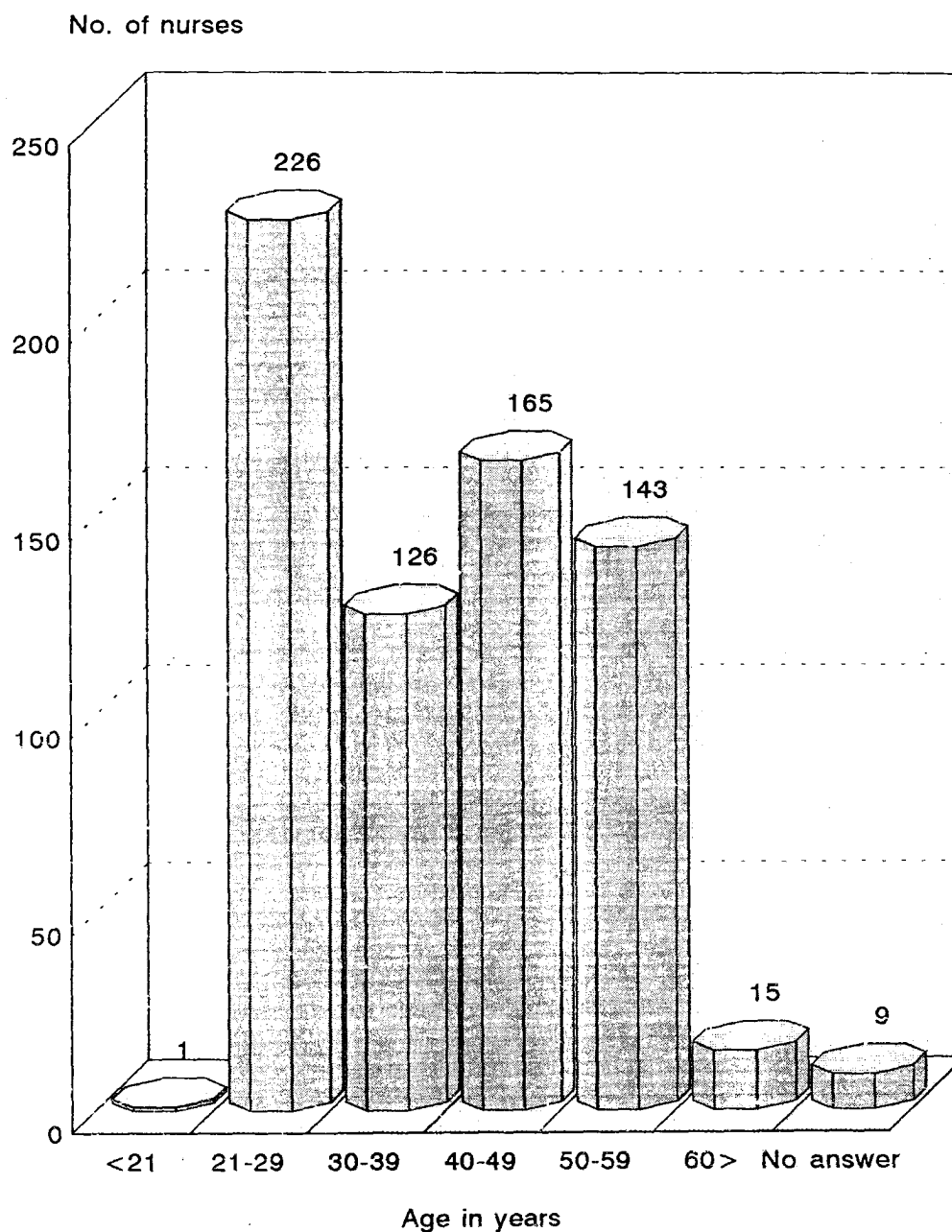
The highest proportion of respondents were S/N's, however, a higher percentage of C/N's responded than S/N's. The reason for this was not clear. However, it may have been that C/N's felt a greater obligation to respond because they had more personal contact with nurse managers who had distributed the questionnaires or because of their sense of overall managerial responsibility for patient care.

FIGURE 16  
SEX OF RESPONDENTS



As expected the majority of nurses were female.

**FIGURE 17**  
AGE OF RESPONDENTS

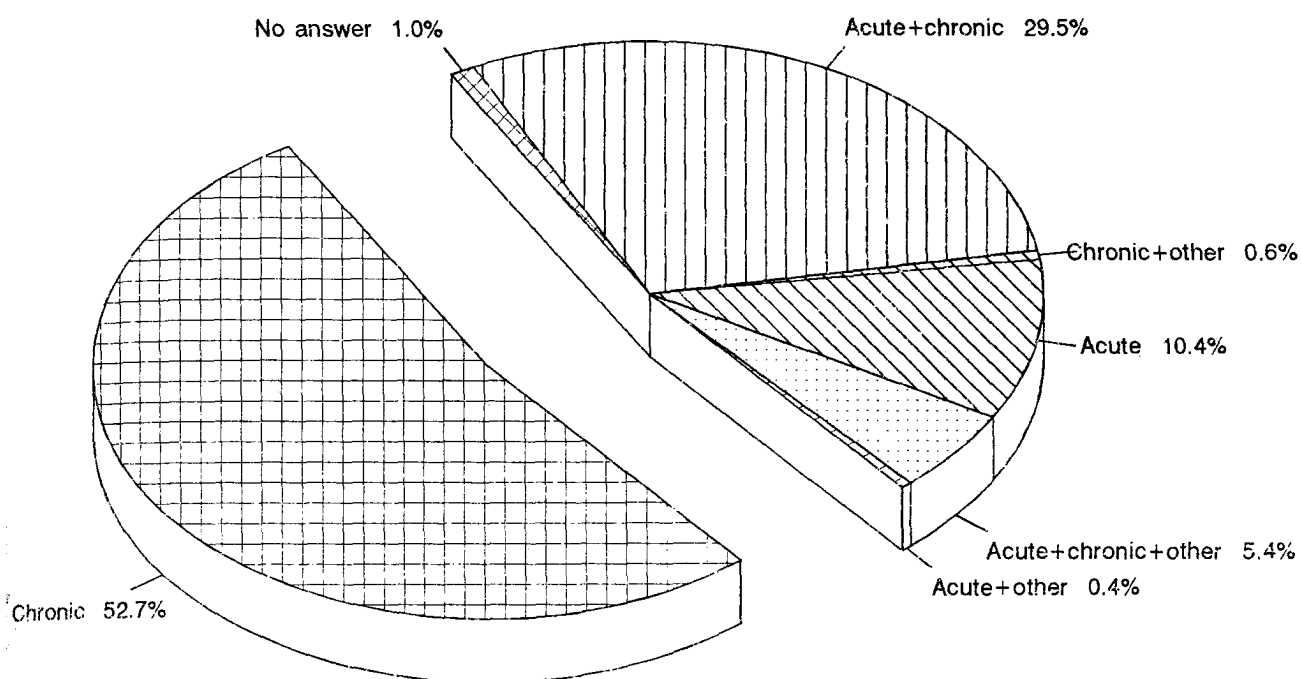


The highest and lowest proportions of nurses responding were aged 21-29 years and under 21 years respectively. This distribution of respondents by age may reflect the proportion of nurses from each age group currently in practice, possible reasons for which are outlined in Table 6 below.

TABLE 6  
POSSIBLE REASONS FOR THE PROPORTION OF NURSES WITHIN EACH AGE  
GROUP CURRENTLY IN PRACTICE

Age group	Possible reason
<21 years	Majority of S/N's are least 21 when qualified
21-29 years	Upsurge of newly qualified S/N's
30-39 years	A drop in numbers due to break in service for child rearing
40-49 years	A slight increase in numbers as women return to work when children are older
50-59 years	A slight drop in numbers as some nurses take early retirement or are promoted to more senior administrative posts
60> years	A sharp drop in numbers due to retirement

**FIGURE 18**  
DISTRIBUTION OF RESPONDENTS ACCORDING TO WARD TYPE



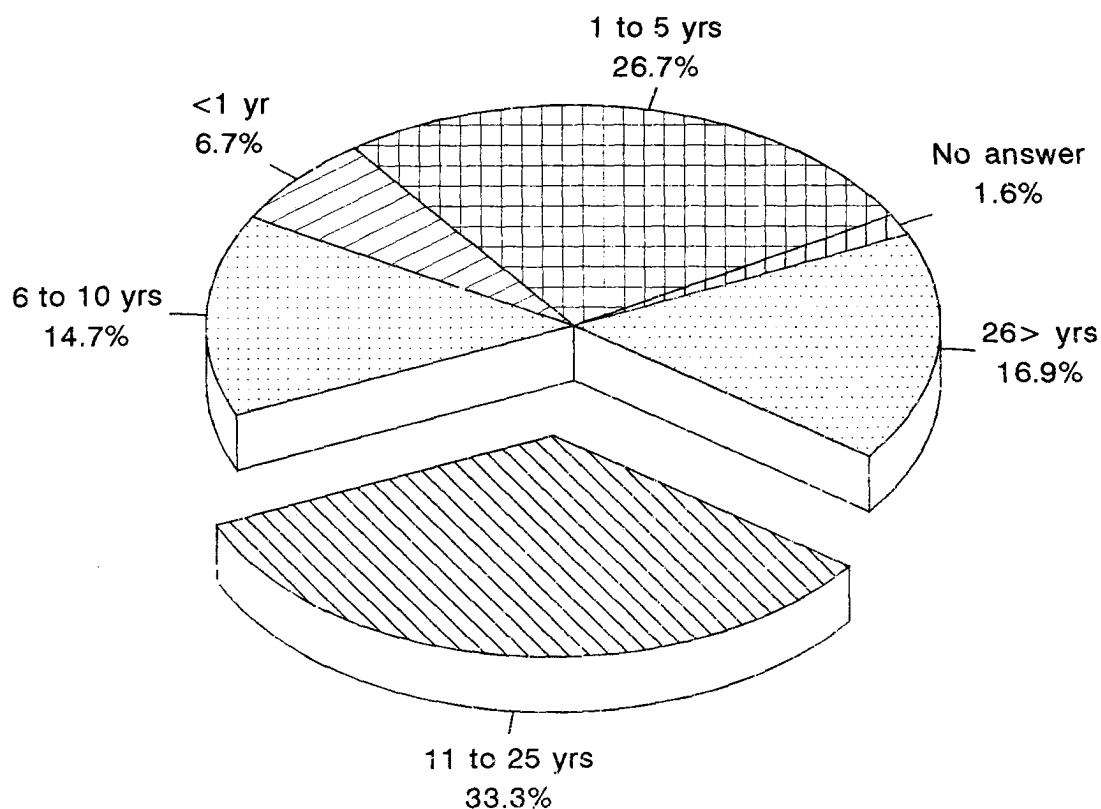
"Other" refers to any ward outwith care of the elderly e.g medical, surgical, thoracic.

The majority of nurses were working on long term care of the elderly wards only (chronic) reflecting of the increasing elderly population in Britain and the predominance of this type of ward in geriatric hospitals where most respondents were situated.



**FIGURE 19**  
**LENGTH OF TIME RESPONDENTS HAD BEEN IN PRACTICE**

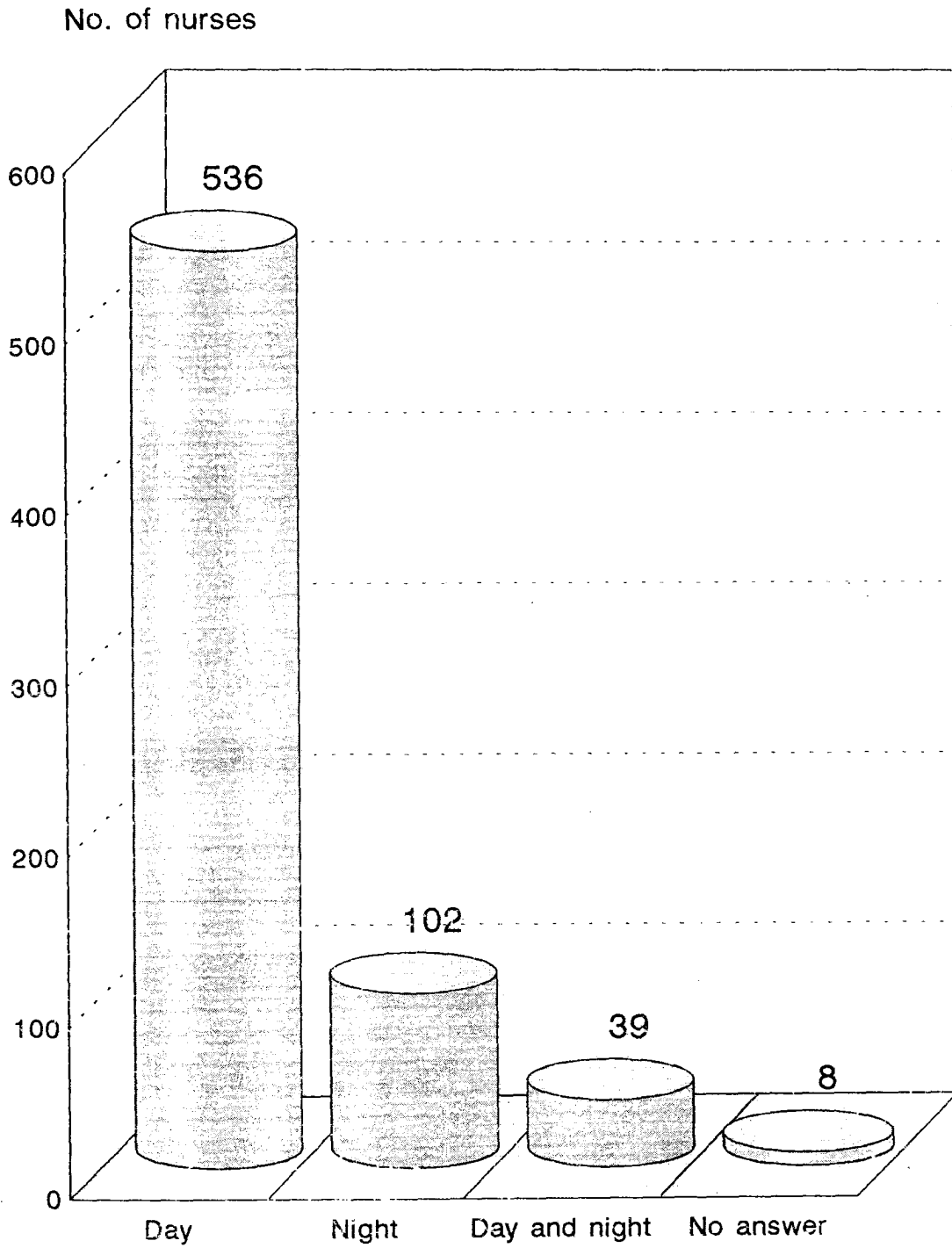
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The length of time respondents had been in practice is probably a reflection of their age. The highest proportion had been in practice 11-25 years and probably reflects the fact that this group could consist of nurses 30 years and over of which there are a substantial number (Figure 17) and can probably be explained by the reasons outlined in Table 6 for the <21, 21-29 and 50-60 year age groups.

**FIGURE 20**

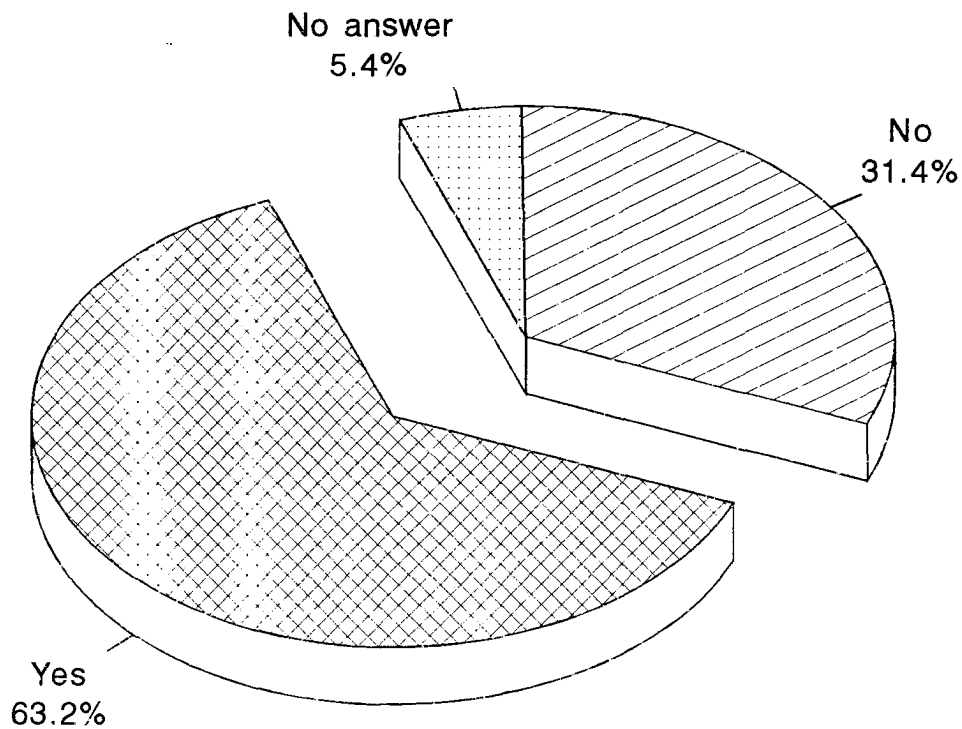
DISTRIBUTION OF RESPONDENTS ACCORDING TO TYPE OF DUTY



As shown in Figure 20, the majority of nurses (536) were working day duty.

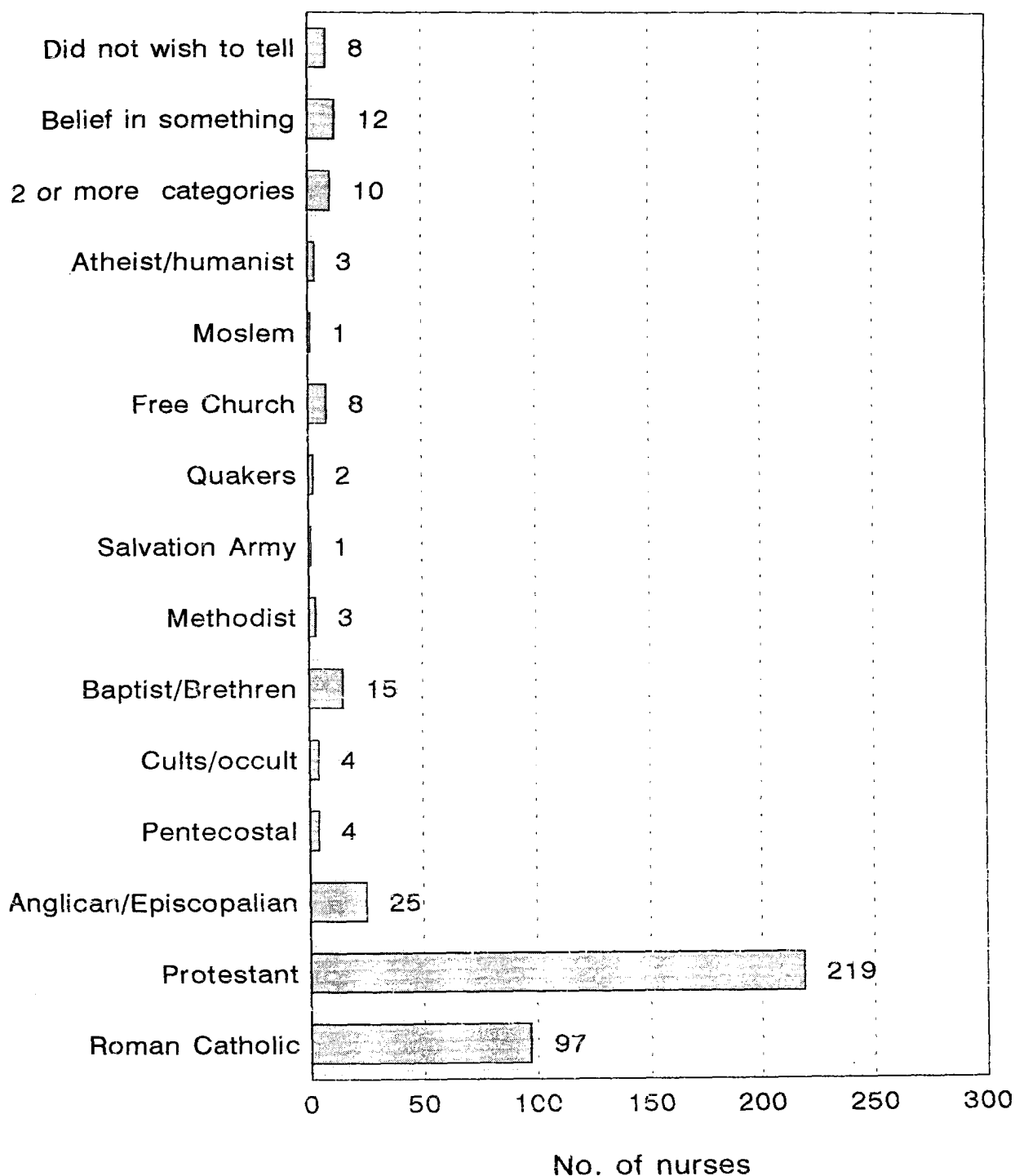
**FIGURE 21**  
**RELIGIOUS AFFILIATION CLAIMED BY RESPONDENTS**

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The majority of nurses claimed to possess some type of religious affiliation. This may be explained by the fact that the majority of people, even if they have merely had nominal church connections e.g. have been christened, would adopt some religious label.

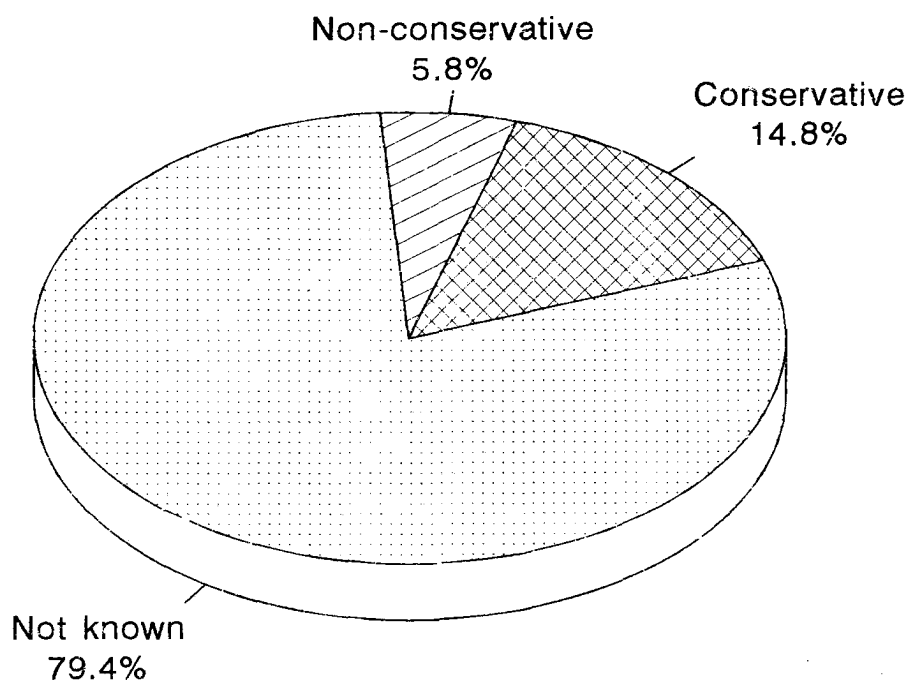
**FIGURE 22**  
TYPE OF RELIGIOUS AFFILIATION CLAIMED BY RESPONDENTS



As Figure 22 shows, of those claiming religious affiliation (n=433), the majority (53.2%) described themselves as protestant (n=219), the majority (53.2%) described themselves as protestant e.g Church of Scotland, Presbyterian, Congregational with smaller percentages classifying themselves as Roman Catholic (23.5%) and Anglican/Episcopalian (6.1%).

**FIGURE 23**  
CONSERVATISM OF BELIEF OF RESPONDENTS

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As it was thought that nurses who were conservative in their belief might view and respond differently to spiritual needs than those with no/nominal religious belief, where possible this distinction was made. Unfortunately, in the majority of cases, it was not possible to ascertain this information therefore any analyses conducted using this variable were limited.

### 3.2 NURSES' PERCEPTIONS OF SPIRITUAL NEED AND CARE AND THEIR REPORTS OF HOW THEY GAVE THIS CARE

In this section nurses' perceptions of spiritual need and spiritual care and how they reported to have given this care are presented and discussed before conclusions are drawn.

#### 3.2.1 Presentation of results

The results are presented in a series of tables.

The tables are ordered according to the sequence in which questions appeared in the questionnaire. As previously outlined, questions B2 and 4.3 were combined.

Throughout, percentages are expressed in terms of the total number of respondents who answered the particular question.

TABLE 7  
NURSES' DEFINITIONS OF SPIRITUAL NEED

<u>Definition</u>		<u>No and % of nurses giving each response</u>	
		<u>No</u>	<u>%</u>
1	Need for meaning, purpose and fulfilment.	64	9.9
2	Need to give and receive love and forgiveness.	91	14.1
3	Need for hope and creativity.	23	3.6
4	Need for belief and faith.	221	34.1
5	Need for peace and comfort.	158	24.4
6	Miscellaneous	90	13.9
	Did not answer the question.	38	

TABLE 8  
NURSES' DEFINITIONS OF SPIRITUAL CARE AND/OR STATED RESPONSES TO PATIENTS' SPIRITUAL NEEDS

<u>Definition/response</u>		<u>No and % of nurses giving each response</u>	
		<u>No</u>	<u>%</u>
1	Recognising/respecting/meeting patients' spiritual needs	44	6.8
2	Facilitating participation in religious rituals.	43	6.7
3	Communicating: listening/talking with.	42	6.5
4	Being with the patient: caring, supporting, showing empathy.	121	18.8
5	Promoting a sense of well-being.	58	9.0
6	Referring to others.	333	51.6
7	Expressed difficulty in defining or giving spiritual care.	4	0.6
	Did not answer the question.	40	

TABLE 9  
PEOPLE NURSES CONSIDERED TO BE RESPONSIBLE FOR RESPONDING TO  
PATIENTS' SPIRITUAL NEEDS

<u>Person</u>		<u>No and % of nurses giving each response</u>	
		<u>No</u>	<u>%</u>
1	Nurse alone	0	0
2	Clergy alone	37	5.6
3	No-one	2	0.3
4	Nurse + clergy	485	73.5
5	*Other (Only in 0.4% of cases did nurses exclude themselves from this role)	136	20.6
	Did not answer the question.	25	

\* Includes any combination of the following: anyone; those outwith the health care team e.g family, friends; clergy + those outwith the health care team; nurse + clergy + those outwith the health care team.

TABLE 10  
NURSES' REPORTS OF WHETHER OR NOT THEY HAD IDENTIFIED A SPIRITUAL  
NEED

<u>Had identified a spiritual need</u>		<u>No and % of nurses giving each response</u>	
		<u>No</u>	<u>%</u>
1	Yes	503	76.8
2	No	152	23.2
	Did not answer the question.	30	



TABLE 11  
INDICATORS NURSES STATED THEY USED IN RECOGNISING PATIENTS'  
SPIRITUAL NEEDS

<u>Indicators</u>		<u>No and % of nurses giving each response</u>	
		<u>No</u>	<u>%</u>
1	The need was expressed by the patient verbally or non-verbally.	155	31.4
2	The need was observed in other ways by the nurse.	111	22.5
3	Through distress displayed by the patient.	125	25.3
4	Through state of helplessness displayed by the patient.	47	9.5
5	Through patient's inability to come to terms with situation.	49	9.9
6	Positive characteristics displayed by the patient.	7	1.4
Did not answer the question.		191	

TABLE 12  
NURSES' EVALUATIONS OF THE EFFECTIVENESS OF RESPONSES MADE TO  
PATIENTS' SPIRITUAL NEEDS

<u>Efficacy</u>	<u>No and % of nurses giving each response</u>	
	<u>No</u>	<u>%</u>
1 Totally effective	146	29.2
2 More effective than ineffective	276	55.2
3 Don't know	55	11.0
4 More ineffective than effective	17	3.4
5 Totally ineffective	6	1.2
Did not answer the question.	185	

TABLE 13  
INDICATORS NURSES STATED THEY USED IN EVALUATING THE  
EFFECTIVENESS OF RESPONSES TO PATIENTS' SPIRITUAL NEEDS

<u>Indicators</u>		<u>No and % of nurses giving each response</u>	
		<u>No</u>	<u>%</u>
1	Eustressing characteristics displayed by the patient.	174	37.6
2	Patient appeared brighter in mood.	48	10.4
3	Patient's ability to accept situation.	35	7.6
4	Patient confirmed that his/her need had been met.	78	16.8
5	Nurse felt that the need had been met. Not necessarily confirmed by the patient.	46	9.9
6	Nurse felt that the need was not met/not completely met.	28	8.0
7	Nurse expressed difficulty in assessing the effectiveness of his/her interventions.	54	9.7
	Did not answer the question.	222	

TABLE 14  
NURSES' STATEMENTS OF WHETHER OR NOT THEY WOULD HAVE RESPONDED  
DIFFERENTLY TO PATIENTS' SPIRITUAL NEEDS

<u>Would have responded differently</u>		<u>No and % of nurses giving each response</u>	
		<u>No</u>	<u>%</u>
1	Yes	50	10.1
2	No	443	89.5
3	Don't know	2	0.4
	Did not answer the question.	190	

TABLE 15  
WAYS IN WHICH NURSES STATED THEY WOULD HAVE RESPONDED DIFFERENTLY

<u>Alternative responses</u>		<u>No and % of nurses giving each response</u>	
		<u>No</u>	<u>%</u>
1	Acted earlier.	3	6.7
2	Spent more time with patient/family.	12	26.7
3	Involved others/sought help.	23	51.1
4	Included spiritual care in the "Nursing Process".	4	8.9
5	Prayed with patient.	3	6.7
Did not answer the question.		640	

TABLE 16  
REASONS FOR NURSES NOT COMPLETING THE QUESTIONNAIRE

<u>Reasons</u>		<u>No and % of nurses giving each response</u>	
		<u>No</u>	<u>%</u>
1	Very private and personal thing.	4	18.1
2	Did not feel able to participate.	4	18.1
3	Spiritual care should be left to the chaplain.	3	13.6
4	No time.	1	4.6
5	Would have preferred to have been invited to respond.	1	4.6
6	Did not feel qualified to give spiritual care.	4	18.1
7	Found questions difficult to answer.	2	9.1
8	Working with the confused elderly who are unable to express spiritual needs.	1	4.6
9	Have not encountered anyone with a spiritual need.	1	4.6
10	Did not feel that the subject could be generalised.	1	4.6
Did not answer the question.		663	

### 3.2.2 Discussion of results

This section consists of three parts. First the results are discussed in general terms. Second they are compared with findings in other studies. Third the main findings are summarised.

#### General discussion of results

As discussed in Chapter 2, the Nursing Process was suggested as the framework within which spiritual care could be given. Nurses' perceptions of spiritual need, spiritual care and their reports of how they gave this care are, therefore, discussed in accordance with the stages of the Nursing Process. In addition the reasons nurses gave for not completing the questionnaire are considered. Reference is made throughout the discussion to the relevant tables in the results section. Unless otherwise stated, the discussion centres on the 685 responses received.

#### Assessment

In general it seemed that nurses had identified patients' spiritual needs, as indicated by the fact that the majority (76.8%) claimed to have done so (Table 10), however it was not possible to determine the extent to which they had identified these needs.

This still meant that 152 nurses (23.2%) had never identified a spiritual need in any patients at any point in their practice. It may have been that none of the patients these nurses looked after had spiritual needs, however, some of them may have done. For those patients who had spiritual needs the implication is that, unless their needs were identified by someone other than the nurse or met by the patient themselves, they may have been overlooked.

Table 7 illustrates that nurses perceived spiritual need in a variety of ways. Three points can be noted from this table, each of which is discussed in turn.

First, the fact that the highest proportion of nurses (34.2%) viewed spiritual need as the need for belief and faith, 31.3% considering it to be religious in nature (Appendix 5), suggests that nurses seemed to view spiritual need in religious terms. This implies that patients' religious needs may have been better recognised than other spiritual needs e.g for hope and creativity.

The literature review highlighted that all people have spiritual needs, regardless of the possession of religious beliefs. Nurses who viewed spiritual need in religious terms only, therefore, may fail to identify spiritual needs in patients who claim no religious affiliation or may assume certain spiritual needs in those claiming a particular religious affiliation. In both

cases, patients' true spiritual needs may not be recognised. Alternatively, given that the study targeted nurses who were caring for the elderly, and that the elderly may have tended to express their spirituality through religion, it may have been that the spiritual needs patients experienced were predominantly religious.

Second, the literature consistently considered the needs for MPF and hope as spiritual needs. The study findings, however, do not appear to be in keeping with the literature as only 9.9% and 3.6% of nurses respectively defined spiritual need in these ways. This implies that nurses may not have addressed the fundamental spiritual needs of MPF and hope or it may have been that the elderly found meaning and hope through religious experiences and practices. Alternatively, nurses may have considered the needs for MPF and hope/creativity as psychological rather than spiritual in nature. This is possible given that 1.5% of nurses in the miscellaneous category viewed spiritual need in this way (Appendix 5). If nurses viewed the needs for MPF and hope as psychological rather than spiritual in nature the danger is that these needs could have been inadequately catered for because spiritual interventions were ignored.

Third, in the miscellaneous category (Table 7), 3.9% of nurses expressed difficulty in defining spiritual need. This small percentage could be representative of the non-respondent group e.g two of the 22 nurses who chose not to complete the

questionnaire did so because they found the questions difficult to answer (Table 16). Thus it could be that the proportion of nurses in the population who were unclear about what spiritual needs were and therefore unsure about what spiritual care involved, was higher than the study findings indicated.

The indicators nurses used in identifying patients' spiritual needs are outlined in Table 11. Given that the common theme in indicators 2-6 and part of indicator 1 is non-verbal/indirect verbal communication, it would seem, therefore, that nurses were mainly alerted to patients' spiritual needs in this way. This finding suggests that spiritual needs may be more subtle and more difficult to identify than other needs e.g certain physical needs.

#### Planning and intervention

Almost all nurses (93.7%) (Table 9) considered it their shared responsibility, with the clergy (73.5%) and others (20.2%) to respond to patients' spiritual needs. The fact that over half (51.6%) in Table 8 referred these needs suggests, however, that most nurses either felt unable to respond or did not consider it their duty to personally respond to patients' spiritual needs. Whatever the reasons, the fact that over half of nurses felt personally unable to respond, referral being the preferred option, suggests that spiritual care may lack continuity.

Some nurses (Table 8) such as those who were prepared to "be with" the patient (18.8%) or listen to/talk with the patient about their situation (6.5%), were however willing to respond personally to patients' spiritual needs. Why some nurses felt personally able to respond whilst others did not was not clear. Additionally, it was not known which spiritual needs the former group of nurses felt able to respond<sup>to</sup> personally.

It is noteworthy that, although 31.3% of nurses viewed spiritual need in religious terms (Table 7 and Appendix 5), only 6.7% considered spiritual care to involve facilitating participation in religious rituals (Table 8). This could be explained if nurses referred patients' religious needs to others.

### Evaluation

As illustrated in Table 12, the majority of nurses (84.4%) considered the interventions employed to meet patients' spiritual needs to have been either totally (29.2%) or partially (55.2%) effective. A minority (4.6%), however, were of the opinion that the care given had been ineffective to a greater or lesser degree.

As Table 13 shows, nurses evaluated the effectiveness of the spiritual care given mainly through observing non-verbal/indirect verbal cues given by patients which were the opposite of those alerting them to patients' spiritual needs in the first place.



It would seem that all but 11% of nurses (Table 12) were able to evaluate the spiritual care given. As the majority would or did refer spiritual needs to others (51.6% Table 8), this would suggest that nurses did not have to be personally involved in responding to patients' spiritual needs to be able to evaluate the extent to which their needs had been met.

Probably because the majority of nurses considered the spiritual care given to have been effective, only 10.1% stated they would have responded differently to patients' spiritual needs (Table 14). Over half of these nurses (51.1%) would have referred to others (Table 15) which may highlight these nurses feelings of inadequacy in dealing with patients' spiritual concerns. Other nurses (26.7% Table 15) would have liked to have spent more time with patients/family which suggests that lack of time could interfere with the practice of spiritual care.

Additionally some nurses found it difficult to evaluate the spiritual care given (11% Table 12) mainly because of patients' unresponsiveness (9.7% Table 13 and Appendix 5) which highlights Hockey's (1979) finding that patient characteristics can influence the nursing care given (Figure 9).

### Reasons for nurses not completing the questionnaire

A very small percentage (3.2%) of nurses stated their reasons for choosing not to complete the questionnaire. As previously mentioned in Section 2.2 of this chapter, it was thought that the reasons nurses gave for not completing the questionnaire (Table 16) might highlight possible characteristics of the non-respondent group (32.2% of the population). As Table 16 shows, a wide variety of reasons were given by nurses. The majority (17 out of 22, or 77%), however, did not complete the questionnaire because they either did not consider spiritual care part of their role (7 out of 22 nurses, reasons 1 and 3) or felt unable to give it (10 out of 22 nurses, reasons 2, 6 and 7).

### Discussion of results in relation to the literature

In the following discussion, the study findings are compared with the literature. As in the previous section, the discussion follows the stages of the Nursing Process.

As outlined in Chapter 1 Section 4, comparisons between studies were made difficult by the fact that operational definitions of terms were frequently lacking or were not cited in summarised versions of the original studies. There was no guarantee, therefore, that the terminology used was consistent across studies. In addition each study had its own limitations.

## Assessment

Whereas in this study the majority (76.8%) of nurses said they had identified a spiritual need at some point in their practice, there was conflicting evidence of this in the other available research.

In Chadwick's (1975) study all nurses stated they had recognised a spiritual need at some time as did the majority in Chance's (1967) study. Additionally Piles (1986) highlighted how 30.7%-50.6% of nurses "often" assessed more general aspects of the patient's spiritual state but that only 15.8% - 18.7% "often" assessed more specific aspects of patients' spiritual needs and 61% "seldom/never" diagnosed spiritual distress.

Other studies highlighted that nurses had a limited awareness of patients' spiritual needs (Highfield and Cason 1983). Only 29.5% of nurses in Kramer's (1957) study considered it their duty to identify a spiritual need for referral to the clergy. Furthermore O'Neill (1984) found that patients' religious needs were not recorded in nursing records.

Collectively as a group nurses' definitions of spiritual need in this study covered all aspects of the operational definition derived from the literature. In addition, nurses mentioned two other aspects of spiritual need not covered by the operational definition. The first was the need for peace and comfort which

was more in keeping with indicators of spiritual well-being cited by Highfield and Cason (1983) (Appendix 1). The second concerned aspects of the miscellaneous category where 4.7% and 3.1% of nurses respectively defined spiritual need in terms of an individual need and deeper need than any other (Appendix 5). These definitions were more akin to the descriptions of the spiritual dimension presented in Section 1 of Chapter 1.

The finding that nurses tended to equate spiritual needs with religious needs was similar to other studies (Chance 1967, Highfield and Cason 1983, Piles 1986, Samarel 1991).

Patients in most other studies reported having experienced spiritual needs which included the need for: meaning; belief in God, often expressed through formal religious practices; relatedness to others/God; relief from conditions such as fear, doubt, loneliness (Martin et al 1976, Simsen 1985, Stallwood-Hess 1969). The fact that all these needs expressed by patients were similarly considered to be spiritual in nature by nurses in this study suggests nurses may be in a good position to be able to identify and respond to these needs.

Chance's (1967) finding was similar to this study in that nurses were mainly alerted to patients' spiritual needs through non-verbal/indirect verbal means of communication e.g emotional

attitudes, tears, gestures. Additionally many of the indicators of spiritual distress and well-being, listed in Appendix 1, could be considered to be non-verbal.

### Planning and intervention

Nurses, both in this and other studies seemed to prefer to refer patients' spiritual needs to others rather than responding to them personally (Chance 1967, Kealey 1974, Piles 1986). Patients in other studies similarly considered the clergy and nurse to have a major role in spiritual care followed by others such as family and friends (Table 17). It was suggested by the author and highlighted by other studies (Chadwick 1973, Highfield and Cason 1983, Kealey 1974, Kramer 1957, Piles 1986) that nurses may have referred patients' spiritual needs because they felt inadequate about giving spiritual care.

Referral of spiritual needs is all very well provided that clergy etc are available. Only one study (Byles 1961) was identified which addressed hospitals' provision of clergy and in this instance only childrens' hospitals in parts of the USA were selected. In over 50% of these hospitals (n=133) policies stated that nurses should refer spiritual matters to others, especially the chaplain, yet less than 20% of hospitals had a full time chaplain and over 50% had no available official chaplain. Thus, although referral appeared to be an accepted

TABLE 17  
SOURCES OF HELP IN SPIRITUAL CARE MENTIONED BY PATIENTS IN OTHER STUDIES

Rank	Person patients considered could help them with their spiritual needs	Author of study
1	clergy  clergy  anyone else (excluding clergy, nurses and any other members of the HCT)  met alone	Martin <u>et al</u> 1976  Stallwood-Hess 1969  Chomicz 1984  Kealey 1974
2	nurses  nurses  God  family	Chomicz 1984  Stallwood-Hess 1969  Kealey 1974  Martin <u>et al</u> 1976
3	family  family, friends and clergy  clergy  nurse	Stallwood-Hess 1969  Kealey 1974  Chomicz 1984  Martin <u>et al</u> 1976
4	friends  friends  other hospital staff (other than nurse, clergy)	Martin <u>et al</u> 1976  Stallwood-Hess 1969  Chomicz 1984
5	doctor  psychiatrist	Martin <u>et al</u> 1976  Stallwood-Hess 1969
6	other hospital staff (other than clergy, nurses, psychiatrist)  God	Stallwood-Hess 1969  Martin <u>et al</u> 1976

intervention, the resources may not have been adequate. Further research would be required to ascertain British hospitals' provision of clergy.

Although over half of the nurses in this study preferred to give spiritual care by referring, it was noted that some (18.8%) would do so by "being with" the patient. This concept of nurses giving spiritual care by their presence and by the use of touch was also noted in other studies (Piles 1986, Martin et al 1976, Samarel 1991, Stallwood-Hess 1969).

Furthermore, some (6.7%) nurses considered spiritual care to involve facilitating participation in religious rituals. In other British studies there was conflicting evidence as to whether or not patients considered religious practices important to them (Chomicz 1984, Simsen 1985). Of those patients who did (Chomicz 1984), the acts of taking communion and attending church services were cited as the most important. Generally American nurses stated that they would feel comfortable about helping patients with prayer and in the reading of religious literature (Chadwick 1973, Chance 1967, Kealey 1974, Kramer 1957), however two studies indicated that, in practice, they tended not to do so (Chadwick 1973, Piles 1986).

There would appear to be some discrepancy, therefore, between nurses' intentions and actions. There could be a number of reasons for this. It may be that the majority of patients do not

consider religious practices important to them, as was found by Chomicz (1984) or it may be that they do (Simsen 1985) but do not consider the nurse the most appropriate person to help in this way. For example the majority of patients (58%) in one study (Martin et al 1976) said they would not like the nurse to pray with/read scripture to them and in another (Kealey 1974) the majority met their spiritual needs through communicating with God personally. Alternatively other factors such as lack of time, as highlighted earlier in this section, may have prevented nurses from carrying out their intentions.

Another group of nurses (6.5%) in this study considered that spiritual care could be given through listening to and talking with patients. Nurses and patients in other studies were also of this opinion (Chance 1967, Kealey 1974, Piles 1986, Stallwood-Hess 1969) and in one study (Martin et al 1976) the majority (77%) of patients considered that nurses could help most by listening.

### Evaluation

The majority of nurses in this study (84.4%) considered the spiritual care given to have been effective. This was a similar finding to that of Chadwick (1973), the only other study identified which addressed nurses' evaluations of spiritual care.



One would expect that if effective spiritual care had been given then patients would have expressed satisfaction with the care they had received. Other studies indicated that in general patients felt their spiritual needs had been met to some extent (Martin et al 1976, Stallwood-Hess 1969). No studies were identified, however, which examined both nurses' and patients' perspectives, therefore, further research which addresses both these issues would be required to ascertain the efficacy of the spiritual care given.

### 3.2.3 Summary

Although there was conflicting evidence in other studies, within the sample in this study, the majority of nurses claimed to have identified a spiritual need in a patient at some point in their practice. It was not possible, however, to determine the extent to which they had done so.

Collectively as a group nurses' perceptions of spiritual need covered all aspects of the operational definition derived from the literature. They viewed it in terms of the individual's need for belief and faith; for peace and comfort; to give and receive love and forgiveness; for MPF; for hope and creativity. They tended, however, to view spiritual need more in religious terms which could indicate that patients' religious needs might be

better identified than other spiritual needs. Furthermore, nurses were alerted to patients' spiritual needs mainly through recognising non-verbal/indirect verbal cues patients displayed.

Although the majority of nurses considered it their shared responsibility to respond to patients' spiritual needs and some were prepared to be personally involved in this, the majority seemed to prefer to refer these needs to others possibly because they felt inadequate. This finding was similarly reflected in other studies.

Nurses seemed able to evaluate the effectiveness of the spiritual care patients had received even if they had not been personally involved in giving this care. Their evaluations were mainly positive and they reached their decision predominantly through observing non-verbal/indirect verbal cues given by patients.

There is suggestion that, as illustrated by Hockey (1979) (Figure 9), nurse, patient and environment related factors may have influenced the spiritual care patients received.

Moreover, lack of time and aspects of the patient's condition e.g if confused or unresponsive, seemed to hinder some nurses from giving spiritual care.

Having described how nurses perceived spiritual need and spiritual care and how they reported to have given this care attention focuses in the following section, on identifying factors which appeared to influence the spiritual care given.

### 3.3 FACTORS WHICH APPEARED TO INFLUENCE THE SPIRITUAL CARE GIVEN

Factors were identified by exploring nurses' responses in the questionnaire and by cross-tabulating certain variables in SPSS. Each approach is explained in turn before the findings are summarised.

#### Exploration of nurses' responses

A number of factors emerged from the responses nurses gave in the questionnaire (Section 3.2) which appeared to influence their giving of spiritual care. These factors were similar to those identified by Hockey (1979) (Figure 9) and were related to the nurse, patient and environment. Each is discussed in turn.

Concerning the nurse, it was suggested by the author that, as patients' spiritual needs were mainly recognised through non-verbal/indirect verbal cues given by the patient, these needs may be more difficult to identify than other needs. Whether or not spiritual needs were recognised may, therefore, be dependent on the sensitivity of the individual nurse. For instance, a

nurse who is insensitive may not pick up on the non-verbal/indirect verbal cues given by the patient, therefore, the patient's spiritual needs could remain unrecognised.

Furthermore, it seemed that some nurses personally responded to patients' spiritual needs whereas others did not. The way in which nurses responded may have been related to their perception of spiritual need and spiritual care and their perception of their role in and ability to give this care, as explained below.

It was suggested that the proportion of nurses in the population who were unclear of what spiritual needs were and therefore unsure of what spiritual care involved, may have been higher than indicated by the study findings. For a substantial proportion of the population, their uncertainty with regard to what spiritual needs and spiritual care were may have prevented them from identifying or personally responding to patients' spiritual needs.

The findings revealed that over half of nurses felt personally unable to respond to patients' spiritual needs. The fact that seven out of 22 nurses indicated that they did not complete the questionnaire because they did not consider spiritual care to be part of their role (Table 16) suggests that, whether or not patients' spiritual needs are identified and the way in which nurses respond to these needs, may depend on their perception of their role in spiritual care.

There is a possible alternative explanation. As discussed above, over half of the nurses referred patients' spiritual needs. Furthermore, over half (51.1%) of those who stated they would have responded differently would also have referred (Table 15) and ten out of 22 nurses did not complete the questionnaire because they felt unable to give spiritual care (Table 16). Thus it would appear that some nurses may not have responded personally to patients' spiritual needs because they perceived themselves to be inadequate. If the nurses who had opted not to complete the questionnaire were representative of the non-respondent group (n=377, Table 5) this would mean that 290 (77% of 377) nurses may have failed to identify spiritual needs and/or give spiritual care because they either did not consider it their duty or felt unable to. Thus the proportion of nurses not identifying patients' spiritual needs and, therefore, not giving spiritual care may have been higher than the findings indicate. Patients' spiritual needs may, therefore, have been less well catered for than the study findings suggest.

In addition to nurse related factors, those connected with the patient also appeared to influence the spiritual care nurses gave. One nurse had not completed the questionnaire because she was unable to identify spiritual needs in the confused elderly (Table 16) whilst others reported difficulty in evaluating the spiritual care given to patients who were unresponsive (Table 13). Thus factors in the patient's condition which interfered with nurse-patient communication

seemed to make it difficult for some nurses to give spiritual care and further highlights Hockey's (1979) finding (Figure 9) that characteristics of the patient may influence the care nurses give.

Concerning environmental factors, lack of time seemed to interfere with the giving of spiritual care (Table 15).

In summary, having explored nurses' responses in the questionnaire it would seem that nurse, patient and environment related factors appeared to influence the spiritual care some nurses gave.

#### Cross-tabulation of variables using SPSS

In order to identify, more reliably, factors which may have influenced the spiritual care nurses gave, variables were cross-tabulated using SPSS. Only factors found to be significant at the 95% level are reported. Four factors, namely geographical location, ward type and the grade and belief system of the nurse were found to be significantly associated with the identification of spiritual needs by nurses. The results are presented in a series of tables before they are discussed.

## Presentation of results

### 1 Health Board area

TABLE 18  
PROPORTION OF RESPONDENTS IN EACH HEALTH BOARD WHO HAD  
IDENTIFIED A SPIRITUAL NEED

<u>Health Board</u>	<u>No</u>	<u>%</u>
Argyll & Clyde	53	91.4
Western Isles	13	86.7
Greater Glasgow	103	83.1
Lothian	102	82.9
Highland	21	80.8
Lanarkshire	26	76.5
Shetland	3	75.0
Grampian	72	72.0
Tayside	50	69.4
Forth Valley	29	67.4
Borders	7	63.6
Dumfries & Galloway	24	53.3

As Table 18 shows, there were variations between Health Boards in the percentage of nurses who had identified spiritual needs.

## 2 Ward type

Ward types were classified into two groups as follows.

1. Nurses working in non-varied wards i.e chronic geriatric ward only or acute geriatric ward only. Included were:

- "long term care" only
- "geriatric assessment and/or geriatric medicine only.

2. Nurses working on varied wards i.e acute and chronic care combined. Included were:

- "acute and chronic geriatric wards combined"
- "chronic geriatric wards combined with other wards outwith care of the elderly"
- "acute geriatric wards combined with other wards outwith care of the elderly"
- "acute and chronic geriatric wards combined with other wards outwith care of the elderly".

The results are shown in Table 19 below.



TABLE 19  
PROPORTION OF RESPONDENTS IN EACH WARD TYPE WHO HAD  
IDENTIFIED A SPIRITUAL NEED

Ward type	Had identified a spiritual need	
	No.	%
Non-varied	307	73.1
Varied	196	83.4

As Table 19 shows, a higher proportion of nurses working on varied wards claimed to have identified spiritual needs compared with those working on non-varied wards.

### 3 Grade of the nurse

TABLE 20  
PROPORTION OF C/N'S AND S/N'S WHO HAD IDENTIFIED A SPIRITUAL NEED

Grade	Had identified a spiritual need	
	No.	%
C/N	216	81.6
S/N	240	72.1

As shown in Table 20, a higher proportion of C/N's than S/N's had identified a spiritual need.

### 4 Belief system of the nurse

TABLE 21  
ACCORDING TO THEIR PROFESSION OF RELIGIOUS AFFILIATION,  
PROPORTION OF RESPONDENTS WHO HAD IDENTIFIED A SPIRITUAL NEED

Profession of religious affiliation	Had identified a spiritual need	
	No.	%
Yes	340	79.4
No	154	72.0

As Table 21 illustrates, a higher proportion of nurses professing religious affiliation had identified a spiritual need than those claiming none. In order to determine if nurses with particular types of religious affiliation identified spiritual needs more readily than others, the two variables were cross-tabulated. Because there were too many groups with low numbers to enable conclusions to be drawn, the fifteen types of religious affiliation were merged into five groups namely:

- Roman Catholic
- Anglican/Episcopalian
- Non-Anglican Protestant
- Combination of all other formal religious groups (Pentecostal, Baptist/Brethren, Methodist, Salvation Army, Quakers, Free Church, Moslem, 2 or more categories)
- Other (cults/occult, those who believed in something, did not wish to reveal type of religious affiliation, atheist/humanists).

The results are presented in Table 22 below.

TABLE 22  
PROPORTION OF RESPONDENTS CLAIMING A PARTICULAR TYPE  
OF RELIGIOUS AFFILIATION, WHO HAD IDENTIFIED A SPIRITUAL NEED

Type of religious affiliation	Had identified a spiritual need	
	No.	%
Roman Catholics	84	88.4
Anglicans/Episcopalians	17	70.8
Non-Anglican protestant	163	74.8
All other formal religious groups combined	38	88.4
Other	24	88.9

Nurses with beliefs not obviously connected with religion ("other" group) were most likely to have identified a spiritual need, closely followed jointly by those in the Roman Catholic and combined religious groups.

Nurses who claimed to be Anglican or non-Anglican Protestants were less likely to have identified spiritual needs.

In summary, having cross-tabulated variables using SPSS the geographical location of the nurse, the type of ward in which she was working, together with her grade and belief system were factors which appeared to be associated with the identification of spiritual needs by nurses. Each finding is discussed in turn below and possible explanations are explored.

## Discussion of results

### 1 Geographical location

No explanation could be identified for the finding that higher percentages of nurses in certain Health Boards identified spiritual needs. It was thought that nurses in these Health Boards may have defined spiritual need in broader terms and, therefore, may have classified a broader range of needs as spiritual compared with nurses who viewed the concept more narrowly. Cross-tabulation of the relevant variables, however, revealed no such association.

Alternatively it was thought that the finding may have been attributable to a factor other than the geographical location of respondents. For instance it could have been that higher proportions of C/N's were located in Health Boards where the highest proportions of nurses reported having identified spiritual needs. This, however, was not the case.

### 2 Ward type

Although a number of reasons are suggested, exactly why a higher percentage of nurses working on varied wards should have reported identifying patients' spiritual needs compared with those working on non-varied wards was not clear.

There is suggestion from Reed and Bond's (1991) work that nurses working on long term care of the elderly wards (non-varied) may experience little satisfaction in their work if they aim for the inappropriate and unachievable goals of cure and/or rehabilitation. It was thought, therefore, that nurses working on varied wards may have experienced greater job satisfaction than those working on non-varied wards which may be more conducive to them maintaining a questioning attitude. They may, therefore, have been more alert to patients' needs in general and, therefore, to their spiritual needs in particular.

Alternatively, unresponsiveness of patients was a factor identified in the previous section which appeared to hinder nurses from giving spiritual care. It is possible that patients in non-varied wards were less responsive than those in varied wards thereby making it more difficult for nurses to identify their spiritual needs.

Moreover, given that there could have been a higher proportion of physically dependent patients located in non-varied wards, this could have meant that nurses on these wards had less time to devote to spiritual care.

### 3 Grade

It was not clear why more C/N's than S/N's claimed to have identified patients' spiritual needs.

It was thought that the identification of spiritual needs may have been a skill acquired with age and experience and that as C/N's were probably older and more experienced than S/N's, this could have explained why they were more likely to have identified spiritual needs. However, although C/N's were significantly older and had been significantly longer in practice than S/N's, no associations were found between age or the length of time in practice and the identification of spiritual needs. The maturity and ability of the nurse to learn may have been more important than her age and length of time in practice in determining her ability to identify patients' spiritual needs. It could have been that these were qualities C/N's possessed in greater measure than S/N's.

Alternatively, it was considered that C/N's may have identified spiritual needs if they were more religious or perhaps perceived spiritual need and spiritual care differently from S/N's. No such associations were, however, found.

Finally, it was suggested that certain aspects of the C/N's role may have given them a certain advantage over S/N's in identifying patients' spiritual needs.

As the key person the C/N may have been privy to more information about patients from a greater number of sources than the S/N and, being less directly involved in giving patient care, she may have been more able to adopt an objective view of the "total" patient.

These factors, combined with her overall responsibility for the total well-being of patients under her care and possibly greater opportunity to attend courses and study days, may have put the C/N in a better position to identify patients' spiritual needs than the S/N. These suggestions are, however, merely speculative and further research would be required to explore the issue of role differences in relation to the identification of spiritual needs.

#### 4 Belief system

It was not clear why a higher percentage of nurses who claimed religious affiliation identified spiritual needs than those claiming none.

There was no difference in the way either of the groups perceived spiritual need or spiritual care. Furthermore, although those who professed to having a religious affiliation were significantly older than those who did not, it cannot be assumed that they were more likely to identify spiritual needs because they were more mature. Further research would be required to ascertain this.

No explanation could be found either to explain why higher percentages of nurses claiming certain types of religious affiliation identified spiritual need than others. Again there was no difference between the groups in terms of their

perceptions of spiritual needs and spiritual care. It was thought that conservatism of belief might offer an explanation, however the only group found to be conservative in their belief was the combined religious group. Conservatism of belief could not, therefore, explain why higher percentages of Roman Catholic nurses and those who held beliefs not obviously connected with religion had identified patients' spiritual needs than those in the other groups.

In summary, although no explanations could be found, C/N's claiming religious affiliation and working on varied wards in certain geographical locations seemed most likely to have identified patients' spiritual needs.

#### 4 SUMMARY

In this chapter attention has focused on Part 1 of the study, namely the quantitative approach.

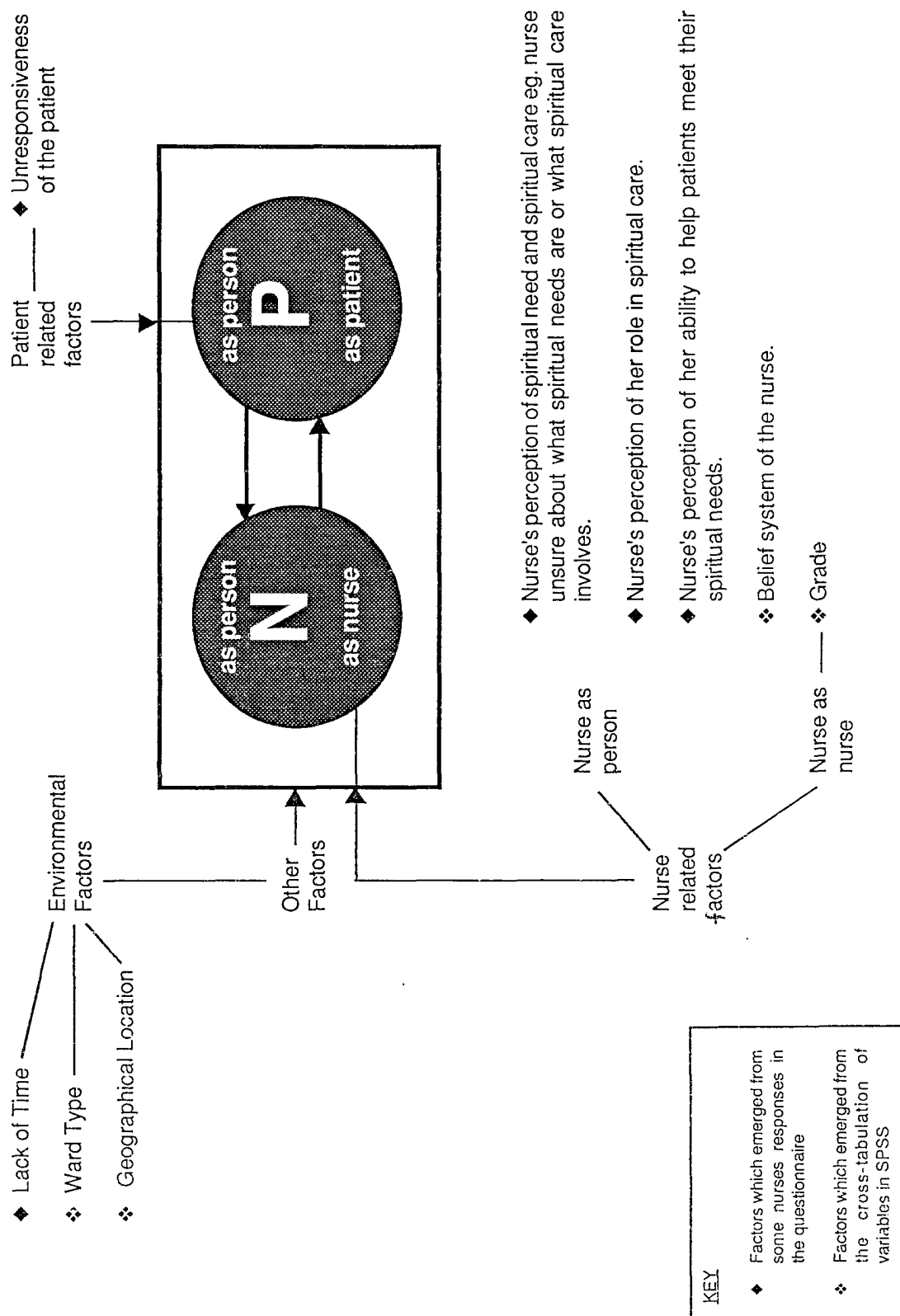
The way in which nurses, within the sample, perceived spiritual need and spiritual care and gave this care in practice was described. It was also found that certain factors, similar to those identified by Hockey (1979) (Figure 9), appeared to influence the spiritual care nurses gave. These factors were



related to the nurse, the environment in which she was working and the patients for whom she was caring and are summarised in Figure 24.

In order to further explore the factors which appeared to influence the spiritual care nurses gave, a different approach was adopted and is described in the following chapter.

**FIGURE 24**  
**FACTORS, EMERGING FROM THE QUANTITATIVE PART OF THE STUDY**  
**WHICH APPEARED TO INFLUENCE SPIRITUAL CARE**  
**(Based on Figure 9)**



## CHAPTER 5

### QUALITATIVE APPROACH

This chapter describes the second part of the study, namely the qualitative approach. The aim and method are outlined before the results are presented, discussed and conclusions drawn.

## 1 AIM AND METHOD

As discussed in Chapter 4 (Section 3.3), several factors emerged from the quantitative part of the study which appeared to influence the spiritual care nurses gave. It was in an attempt to further explore these factors that semi-structured interviews were conducted with a sample of nurses. Although it was acknowledged that, because of the sample size, the results would not be generalisable, it was considered that they would make a valuable contribution in highlighting possible factors which may have influenced the spiritual care given by the sample of nurses.

### 1.1 DESIGN OF THE INTERVIEW SCHEDULE

As the purpose of the interviews was to explore individual nurses' experiences in greater depth than had been achieved through the questionnaire, both standard questions and those relevant to the individual nurse's experiences were included in the interview schedule (Appendix 6).

## 1.2 SELECTION OF THE SAMPLE

It emerged from analysis of data in the quantitative part of the study that there was a geographical difference in the identification of spiritual needs by nurses (Chapter 4, Section 3.3). The sample of nurses for interview was, therefore, selected from three Health Boards namely: Argyll and Clyde which had the highest percentage of nurses identifying spiritual needs; Dumfries and Galloway which had the lowest percentage; Lothian which was in the middle range and was also practical in terms of travel.

Nurses were divided into four groups as follows:

Group 1: those who stated they had not identified a spiritual need

Group 2: those who stated they had identified a spiritual need but did not say how they had recognised it, responded or evaluated the care given

Group 3: those who stated they had identified a spiritual need and considered their interventions to have been totally effective

Group 4: those who stated they had identified a spiritual need but considered their interventions to have been more

ineffective than effective.

Because of the time constraints it was not possible to interview all nurses in all four groups. It was intended, therefore, to select, from each Health Board, one nurse from each of the four groups for interview i.e twelve nurses. However, as only one nurse met with the criteria for Group 2, this left ten potential interviewees who were selected on the basis of the following criteria.

#### 1 Their belief system

As nurses' profession of religious affiliation had emerged as a significant factor in the identification of patients' spiritual needs (Chapter 4, Section 3.3) it was considered important to include nurses with and without religious affiliation.

#### 2 Their stated responses

Some nurses responded personally to patients' spiritual needs whereas others did not (Table 8). By including both types of nurses it was hoped to isolate factors which may have influenced the way in which they responded.

### 3 Their stated evaluations

Some nurses appeared to evaluate the effectiveness of care given by focusing on the patient e.g patient seemed content, whereas others did so on the basis of whether or not an event had occurred e.g the minister had visited (Table 13). By targeting both types of nurses it was intended to elicit factors which appeared to determine how they evaluated spiritual care.

Where there were several nurses to choose from in relation to the above criteria, those who gave the most comprehensive answers were selected. Researcher bias was acknowledged in this process. Where there was no obvious difference between responses, nurses were chosen at random.

In this way ten nurses were selected for interview. On checking the sample these nurses represented all grades and ward types, factors which were previously identified in association with the recognition of spiritual needs by nurses (Chapter 4, Section 3.3).

As all nurses in the sample who had identified a spiritual need also claimed some form of religious affiliation, it was decided to add a nurse, from Lothian Health Board for ease of travel, who had identified a spiritual need but claimed no religious affiliation.

out of interest it was decided also to include an atheist in the sample, although it was acknowledged that this provided no basis for any assumption about atheism in nursing. Two atheists were identified, one in Tayside Health Board and another in Grampian. As the latter had left employment the former was included.

The final sample, therefore, consisted of twelve nurses who varied in their geographical location, grade, ward type, belief system and the way in which they responded to patients' spiritual needs and evaluated the care given.

### 1.3 OPERATIONALISATION OF THE QUALITATIVE PART OF THE STUDY

Having selected the sample, the appropriate hospitals were telephoned to check that the nurses were still working there. Forwarding addresses of those who had changed employment were obtained. All twelve nurses were then invited to participate in semi-structured tape recorded interviews at venues of their choice (Appendix 6). They were asked to complete and return a form detailing their home telephone number and the most convenient time for the researcher to telephone to arrange a time for interview (Appendix 6). Consent was assumed when nurses gave this information. Where replies had not been received ten days after the mailing of the first letter, a reminder letter was sent (Appendix 6). In instances where this failed to achieve a response a substitute nurse was contacted using the procedure already described.



All interviews were conducted by the researcher who was aware of the bias that this would introduce. In eleven of the interviews the researcher met with the nurses and tape recorded the sessions. A telephone interview took place with the nurse from Tayside Health Board because the travelling which would have been required to conduct one interview was considered uneconomical.

All interviews were transcribed.

#### 1.4 ANALYSIS OF THE INTERVIEWS

It appeared to the researcher that different nurses identified different types of spiritual needs and that they recognised them, responded and evaluated at different levels as illustrated in Figure 25. Thus, overall, some nurses gave spiritual care at a deeper level than others as shown in Figure 26.

The spiritual needs nurses identified and the care they reported to have given were, therefore, classified according to the types of need and levels of care illustrated in Figure 25.

Factors which appeared to influence the spiritual care nurses gave were elicited by examining the interview transcripts namely by:

- 1 noting nurses' explanations for some of the findings in the quantitative part of the study

2 identifying factors nurses suggested did/could influence the spiritual care given

3 exploring with nurses some of their responses in the questionnaire

4 noting factors which, according to the researcher, appeared to have some bearing on the spiritual care nurses gave

5 exploring characteristics of nurses in relation to the level of spiritual care they gave.

The results of each of the above analyses are presented in turn in the following section.

Although the researcher endeavoured to conduct the above analyses as objectively as possible, researcher bias could not be ruled out. The reader is reminded that references to what nurses "did" refers to what they "said they did".

**FIGURE 25**  
**TYPES OF SPIRITUAL NEEDS IDENTIFIED BY NURSES**  
**AND THE LEVEL OF SPIRITUAL CARE GIVEN**

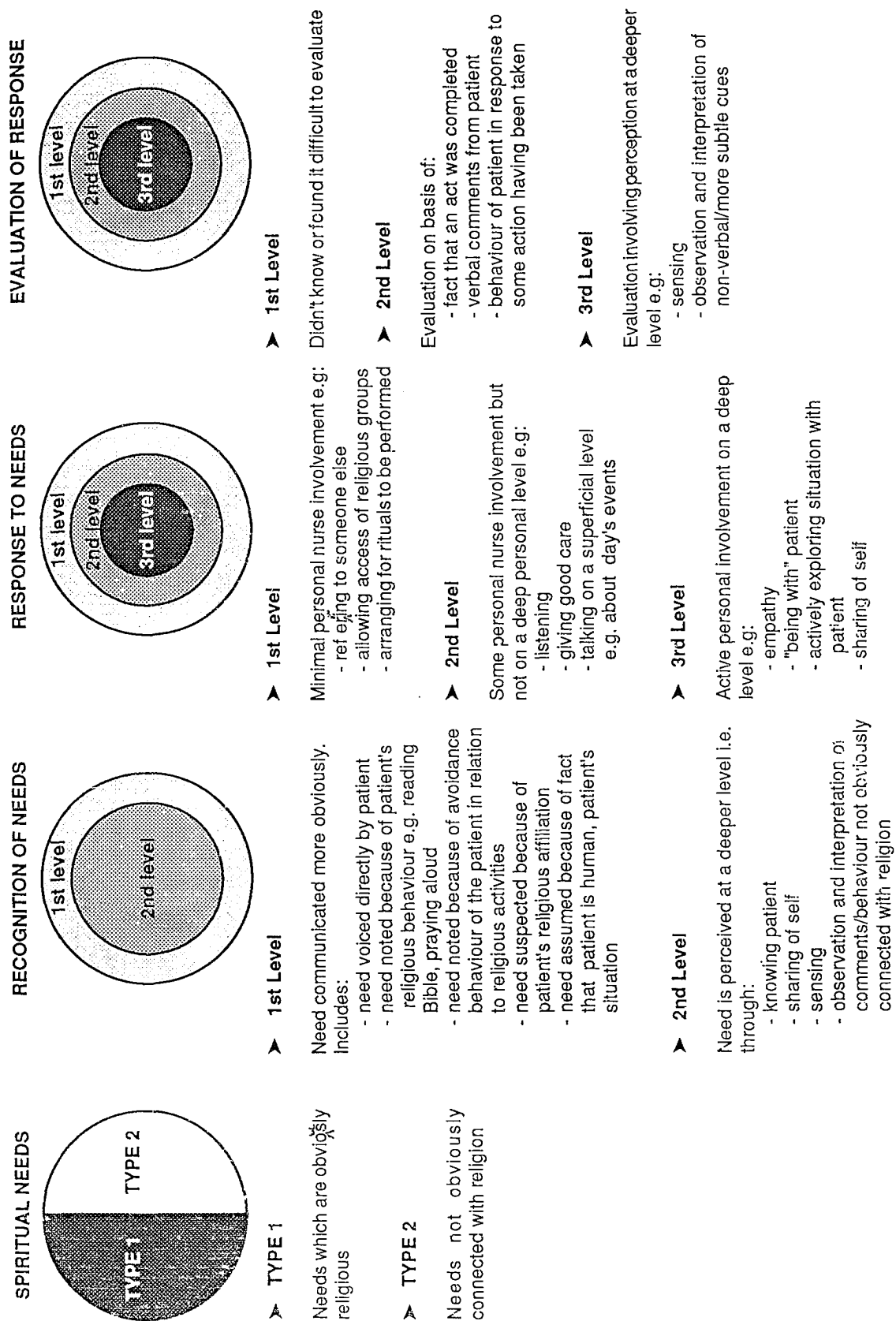
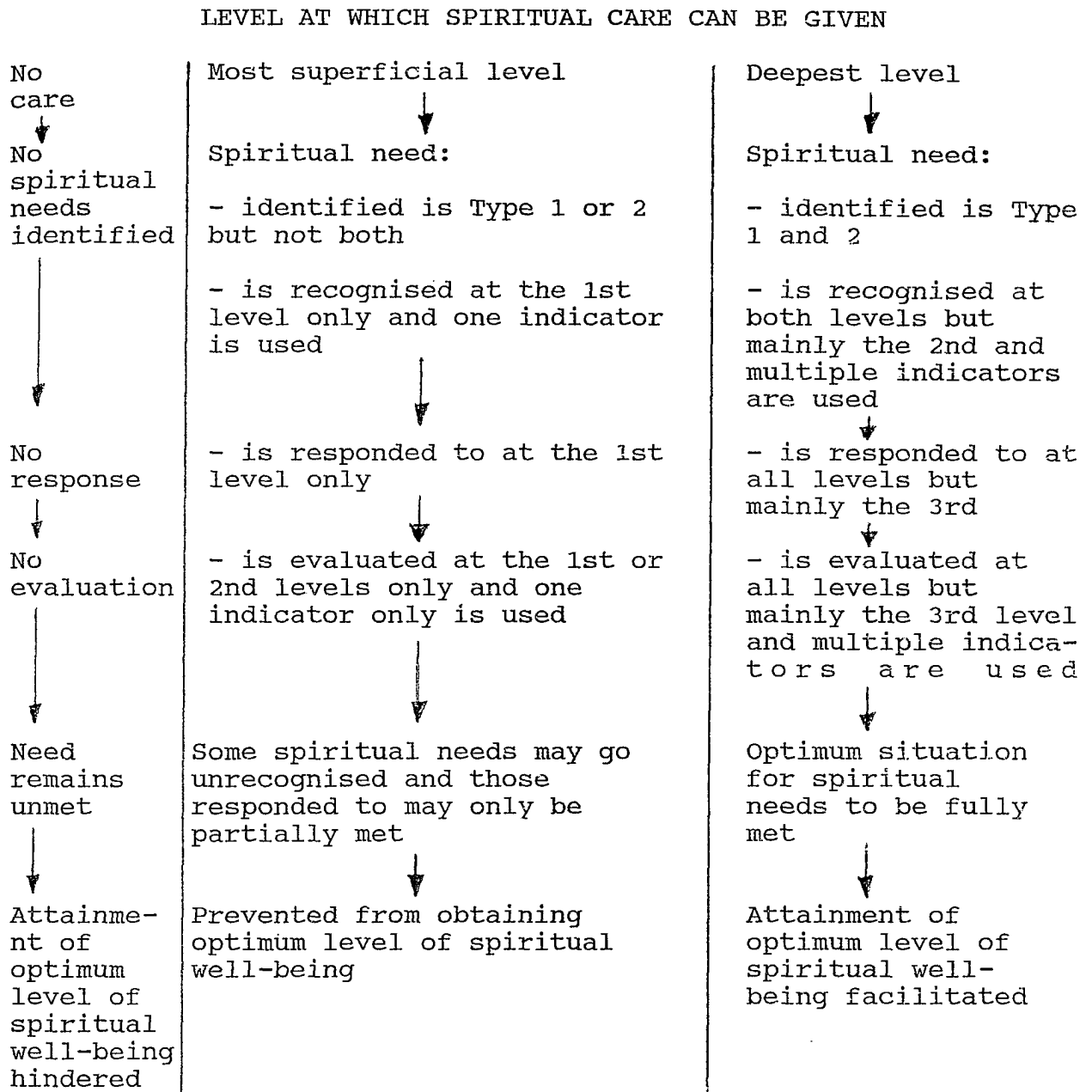


FIGURE 26  
LEVELS AT WHICH SPIRITUAL CARE, AS AN ENTITY, CAN BE GIVEN



## 2 RESULTS

### 2.1 NURSES' EXPLANATIONS FOR SOME OF THE FINDINGS

Interviewees were asked if they could think of possible reasons for the associations found between grade and ward type, and the identification of spiritual needs by nurses. Of the twelve nurses interviewed, eight offered explanations.

Nurses considered that C/N's may have been in a better position to identify patients' spiritual needs than S/N's because of their overall responsibility for patient care, together with the fact that they are usually privy to more information and less involved in giving nursing care. Similar suggestions had previously been given by the author (Chapter 4, Section 3.3).

Also, in a similar vein to the author (Chapter 4, Section 3.3), they felt that nurses working on non-varied wards may have reported identifying fewer spiritual needs than those working on varied wards because staff may have been more institutionalised or patients less communicative. In addition they suggested that nurses working on varied wards may have had greater exposure to acute situations involving unexpected or untimely death than nurses working on non-varied wards where death may have been an expected outcome. Nurses may, therefore, have been more likely to encounter the "why" questions and those concerned with meaning which are fundamental spiritual issues.

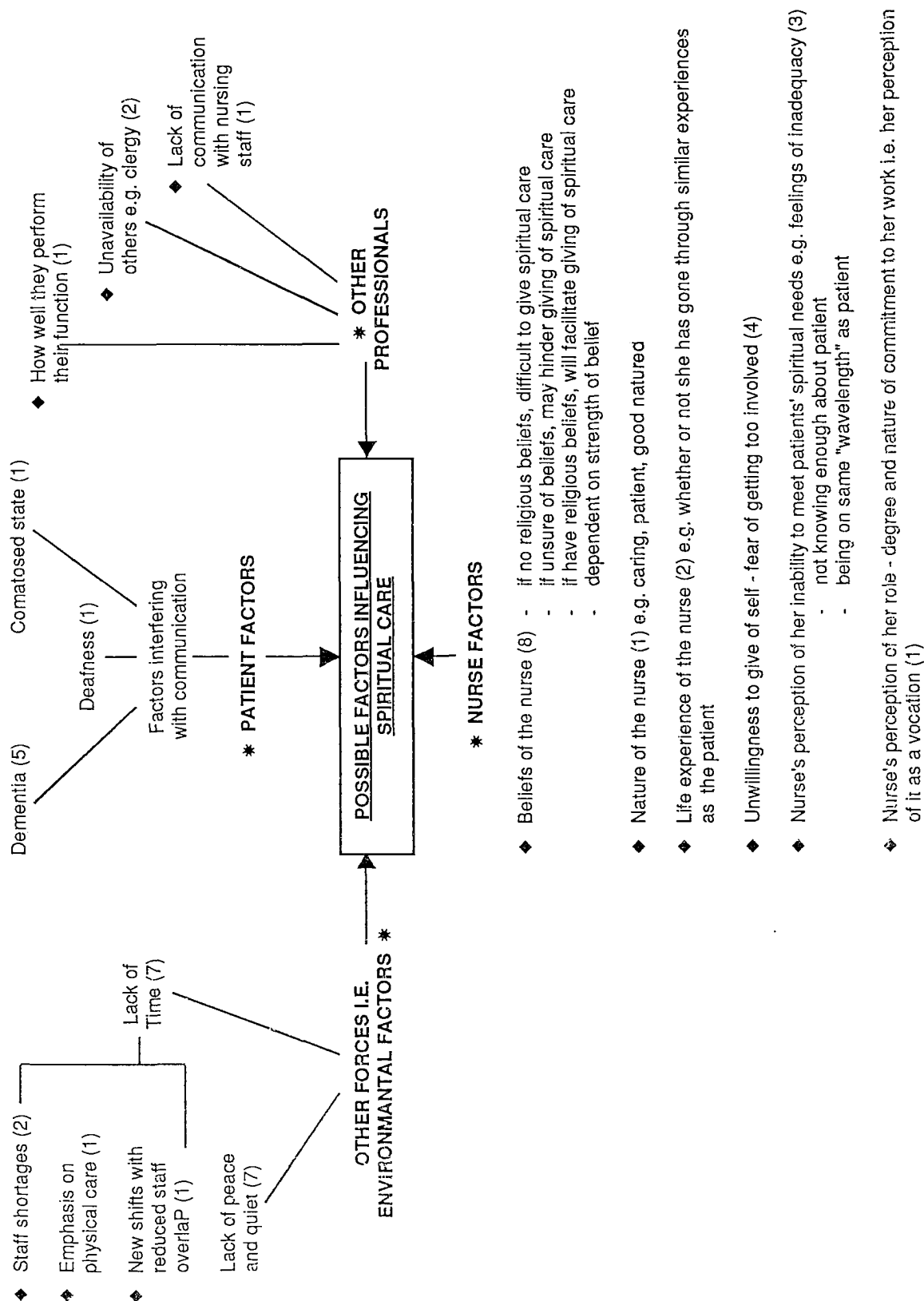
## 2.2 FACTORS NURSES SUGGESTED DID/COULD INFLUENCE THE SPIRITUAL CARE GIVEN

In the course of the interviews nurses suggested a number of factors which they felt had or could have influenced the spiritual care given to patients.

These factors are illustrated in Figure 27 and are clustered under the headings used by Hockey (1979) (Figure 9). In brackets beside each factor, the number of nurses who were of this opinion is stated.

Figure 27 shows that nurses considered a wide variety of factors as influential in spiritual care. These included factors relating to the nurse, the support of other professionals, the environment in which she was working, and the type of patients for whom she was caring.

**FIGURE 27**  
**FACTORS NURSES SUGGESTED COULD/DID**  
**INFLUENCE THE SPIRITUAL CARE GIVEN**



### 2.3 EXPLORATION WITH NURSES OF SOME OF THEIR RESPONSES IN THE QUESTIONNAIRE

In the questionnaire some nurses stated that they had not identified any spiritual needs. Others stated they had but did not indicate if or how they had responded whilst others evaluated the care given from totally effective to more ineffective than effective. By exploring at interview their written responses, it was hoped to obtain some idea of the factors which appeared to prevent nurses from identifying and responding to patients' spiritual needs and those which hindered or facilitated effective spiritual care from being given. Each is discussed in turn.

#### Factors which appeared to prevent nurses from identifying spiritual needs

Three nurses in the sample stated that they had not identified spiritual needs, the reasons given by them being connected with their belief system.

First they equated spiritual needs with religious needs. As they did not consider themselves to be religious people or to know much about the subject, they felt unable to identify these needs in patients. They indicated that education with regard to the latter would be of no benefit to them because they did not consider spiritual care to be part of the nurse's role.



Second, as they were of the opinion that peoples' beliefs were a personal and private matter, they considered it inappropriate for them to ask patients about their spiritual needs.

It emerged at interview that all three nurses who had originally stated that they had not identified any spiritual needs had actually done so, but they had only become aware of this through discussion.

The spiritual needs recognised by them were exclusively concerned with patients' religious needs e.g to attend mass, and were identified at the most superficial level e.g through patients' voicing their needs directly. Furthermore, nurses responded to these needs with the minimum of personal involvement e.g contacted the priest, and evaluated the care given by the fact that an act had been completed e.g the priest had visited.

These nurses also demonstrated a number of other characteristics as described below.

1 They did not seem to know much about the spiritual dimension in general. For instance, they stated they were lacking in knowledge in this respect, had never really thought about it before and found the questions in the questionnaire difficult to answer as illustrated by the following quotations taken from their transcripts:

"...you were making me think about all sorts of things that I don't usually delve into in any great depth."

"...I don't really like this question...I find that very difficult (defining spiritual need)".

2 They perceived themselves as inadequate in helping patients with their spiritual needs e.g one nurse said openly:

"...I would feel extremely inadequate if they (patient) did start to speak like that to me (about God)..."

Another nurse stated that the lack of courage of the nurse might be a factor which would determine whether or not she gave spiritual care. She said that she was personally afraid of getting too close to patients. This perhaps reflected her own feelings of inadequacy in dealing with patients' non-physical needs of which spiritual needs are part.

3 Nurses indicated that they felt spiritual needs would become more apparent during crisis but gave no personal examples of crises they had faced to illustrate the point they were making. This may have been because they considered such experiences too personal to share. Alternatively they may never have personally encountered any crisis situations.

4 Nurses did not seem to demonstrate a personal search for meaning and purpose in their own lives e.g they did not question why things had happened in their lives or in the lives of people close to them. If they had not experienced crises such questions may not have arisen.

In summary, it became apparent at interview that the three nurses who had indicated in the questionnaire that they had never identified a spiritual need, had actually done so. The reason given by them for this was connected with their belief system. Because they equated spiritual needs with religious needs, considered their beliefs private and themselves to be non-religious, they stated that they had not identified any religious needs.

Other characteristics of these nurses were noted by the researcher which may have been connected with their limited awareness of/ability to identify patients' spiritual needs and their tendency to give spiritual care at a superficial level. These included: their limited personal awareness of the spiritual dimension; their perceived inadequacy in helping patients with their spiritual needs; their apparent lack of life experiences such as crises which may have caused them to encounter spiritual needs personally and which may have been connected with their apparent lack of personal search for meaning. All of these factors could have stemmed ultimately from their belief system.

In addition these nurses differed in their grade and the type of ward and Health Board area in which they were working which may suggest that these factors were less important than the nurse's belief system and other personal characteristics in determining their identification of patients' spiritual needs.

Factors which appeared to prevent nurses from responding to patients' spiritual needs

Only one nurse in the sample had stated in the questionnaire that she had identified a spiritual need but did not indicate how she had responded. It emerged that she had experienced difficulty in answering the questions because she had not really thought about it before. This, coupled with lack of time, meant that she did not complete any of the other questions.

Through discussion, it emerged that she had identified a broad range of spiritual needs in patients (Figure 25) and had recognised them by patients communicating these directly e.g crying and by perceiving them at a deeper level herself e.g knowing the patient. She had responded by being personally involved to some extent e.g talking with patients, but she had referred patients' religious needs and those concerned with forgiveness to the clergy. On one occasion she had been involved at a deep personal level with a bereaved patient who was experiencing a situation she had recently encountered personally and had come to terms with. She evaluated the care she had given, in this instance, at the deepest level but experienced difficulty in evaluating in instances where patients were deaf or demented.

It would appear, in this case, that the life experience of the nurse was a factor which enabled her to give spiritual care. Other factors which interfered with the giving of spiritual care included deafness and dementia in patients for whom she was caring.

Other characteristics of this nurse were noted by the researcher as described below.

Although she did not consider herself a religious person she defined spiritual need in both religious and non-religious terms as indicated in her statement:

"I feel it's between peoples' religious needs maybe and emotional needs which are surely tied up together."

and had identified both types of spiritual needs in patients. It would appear, therefore, that the spiritual needs she identified were in keeping with her perception of the term.

Furthermore, she stated that she felt unable to personally help patients with their religious needs because she was unsure of her own beliefs as illustrated in her statement:

" I think...my bit wouldn't be...I don't think I would ever sort of talk about God to them. I would...talk about it in a more...emotional way rather than a religious way...probably the clergyman would talk about it more directly...because I'm so mixed up in my own religious beliefs..."

Thus it appeared that this nurse's belief system i.e the uncertainty of her beliefs, influenced the way she responded to patients' spiritual needs i.e by referring to the clergy.

Although conclusions cannot be drawn from one nurse's experience, in this instance, lack of time and a limited awareness of the spiritual dimension in her own life, were factors given by this nurse for not having articulated the spiritual care she had given.

Further factors noted by the researcher which appeared to determine how spiritual care was given by this nurse included her perception of spiritual need, belief system, life experience and characteristics of patients which interfered with nurse-patient communication.

Factors which appeared to hinder the giving of effective spiritual care

None of the nurses in the sample considered the spiritual care given to have been totally ineffective. Three, however, considered it to have been more ineffective than effective because the patient's distressed condition remained largely unchanged.

They gave three reasons for this. First, they felt inadequate about personally helping patients with their spiritual needs because of their own lack of beliefs, fear of dealing with

situations which they had personally not come to terms with or lack of experience in dealing with these needs. Second, they felt that lack of privacy and time meant that patients' spiritual needs were not adequately dealt with. Third, interventions which had been planned had not been carried out e.g the minister had not been contacted.

Factors which appeared to facilitate the giving of effective spiritual care

In the three instances where nurses had evaluated the spiritual care given as totally effective, the reason they gave was that previously noted distressing characteristics of the patient had been replaced by eustressing ones.

These nurses had recognised both types of spiritual needs, had given spiritual care at the deepest level and had not been hindered from doing so by any extraneous factors.

In conclusion, having explored with nurses some of their responses in the questionnaire, it seemed that the spiritual care given was determined by four main factors as outlined below.

1 Smooth running of the Nursing Process in relation to spiritual care (Figure 8).

Effective spiritual care seemed to be facilitated when the Nursing Process flowed smoothly and when a change for the better in the patient's condition was noted. Ineffective spiritual care seemed to result when the Nursing Process was interrupted and there was little change in the patient's condition.

## 2 Nurse related factors.

The nurse's limited awareness of the spiritual dimension in her own life/lack of beliefs, lack of life experience or feelings of inadequacy in helping patients with their spiritual needs were factors which appeared to interfere with the giving of effective spiritual care.

## 3 Patient related factors.

In instances where patients were deaf, demented or unconscious it was difficult for nurses to identify their spiritual needs or evaluate the care given.

## 4 Environmental factors.

Lack of time and privacy interfered with the giving of spiritual care in some instances.



#### 2.4 FACTORS NOTED BY THE RESEARCHER WHICH APPEARED TO HAVE SOME BEARING ON THE SPIRITUAL CARE NURSES GAVE

When conducting the interviews it appeared to the researcher that the belief system of the nurse, her personal search for meaning and her perceptions of spiritual need and spiritual care were factors which seemed to determine the spiritual care she gave. Each factor is explored in turn.

##### 2.4.1 Belief system

It seemed that nurses, who were not necessarily religious but demonstrated an awareness of God who was in ultimate control of their existence, were more aware of patients' spiritual needs and gave spiritual care at a deeper level than those who did not display these characteristics.

To enable the researcher to explore this hypothesis, nurses in the sample were classified according to whether or not they demonstrated these characteristics. These attributes were considered to be present if nurses made comments similar to those given below.

##### Comments indicating that nurses were aware of God in their own lives

"...The need to think of things on a higher plane...having something to look up to, either a God or something else..."

"...deep down most...individuals want to please God...to be in harmonious relationship with the creator...and it's there whether they admit it or not."

"...we all have this need...that there's somebody up there who's got the answer to the whole complex issues we all face."

" When I was a child...I did have a warm feeling that God was there...but somewhere along the line, I don't have that warm feeling. I'd like to get it back again and I don't know how to get it back."

"...you begin to think...a wee bit more deeply about what's maybe on the other side."

It was considered that nurses were not aware of God in their lives if they: made no comments about this or stated that they believed in the existence of God but did not relate it to their lives; indicated that they knew nothing about the spiritual dimension or had never really thought about it. Examples of comments indicative of the latter were:

" To me spiritual is...religion...I really am not a very religious person myself so it would be a subject i wouldn't know what I was talking about really...I'm not going to be very good at this at all. I really don't know. It's something I really don't know anything about."

"...my immediate reaction was good grief how am I going to fill it in (the questionnaire)...I put it away for quite some time and I got it out again...I found that really quite difficult. I haven't really thought about it...You're making me think of all sorts of things...I never bothered my head about...this is really rotten."

" I don't think about it...I'm not religious...the good thing...was it made me think about it which I hadn't really thought about before."

Having set the above criteria and having previously ascertained the type of spiritual needs each nurse had identified and the level at which she had given spiritual care, it was possible to compare nurses' awareness of God with the level at which they gave spiritual care.

Comparison of the nurse's awareness of God with the level at which they gave spiritual care

The comparison of the above is shown in Table 23.

As this table illustrates, nurses who demonstrated an awareness of God identified a broader range of spiritual needs and gave spiritual care at a deeper level than those who did not i.e they identified , responded and evaluated at a deeper level.

However, the nurse's awareness of God does not explain why some nurses who did not possess this attribute recognised both types of spiritual need at the deepest level and responded at the deepest level. It was decided, therefore, to look at how consistently individual nurses, who did not demonstrate an awareness of God, gave deep or superficial spiritual care.

Table 23 shows that, with the exception of nurse 6, all nurses who demonstrated an awareness of God consistently gave spiritual care at the deepest level i.e they had all recognised the spiritual need, responded to it and evaluated the effectiveness

**TABLE 23**  
**TYPE OF SPIRITUAL NEEDS IDENTIFIED AND CARE GIVEN BY NURSES IN**  
**RELATION TO THEIR PERSONAL AWARENESS OF GOD**

	Aware of God						Unaware of God					
Subject No.	1	2	3	4	5	6	7	8	9	10	11	12
Type of needs identified	1+2	2	1+2	1+2	2	2	3	3	3	1+2	2	1+2
Level at which needs recognised	ab	b	b	ab	ab	b	a	a	b	ab	b	a
Level of response	o	mo	mo	mo	mno	n	m	mn	m	mno	mo	mo
Level of evaluation	yz	xyz	xyz	xyz	xyz	z	y	y	xyz	xyz	yz	xy

KEY Terms as defined in Figure 25

Type of spiritual needs identified:

1 = Type 1 needs

2 = Type 2 needs

3 = stated initially that they had not identified a spiritual need but at interview it emerged that they had identified religious needs only

Level at which spiritual needs were recognised:

a = 1st level

b = 2nd level

Level at which nurses responded to patients' spiritual needs:

m = 1st level

n = 2nd level

o = 3rd level

Level at which nurses evaluated spiritual care given:

x = 1st level

y = 2nd level

z = 3rd level

of this response at the deepest level. It emerged at interview that nurse 6 was unsure of her beliefs which may have explained why she was unable to respond to her patient's spiritual need at the deepest level.

Concerning the group of nurses which did not demonstrate an awareness of God, 1/3 gave spiritual care consistently at the deepest level i.e recognised, responded and evaluated at the deepest level. Thus, although it would appear that those who demonstrated an awareness of God in their lives were more likely to consistently give spiritual care at a deep level than those who did not, it did not seem to be a necessary requirement.

#### 2.4.2 Personal search for meaning

It seemed that nurses who appeared to be searching for meaning in their own lives were more aware of patients' spiritual needs and gave care at a deeper level than those who did not. Nurses were classified, by the researcher, according to whether or not they demonstrated search for meaning. It was assumed they demonstrated this characteristic if they made comments similar to those listed below:

"...what meaning you make of your life...and how you conduct yourself so that your conscience is leading you so that in the end you maybe hopefully go to heaven or something similar."

" I think the meaning of life varies through your life. There are different facets to it...everything in life gives life meaning".

As stated above, it was assumed that nurses were not searching for meaning in their lives if they made no reference to this throughout the interview. Having classified nurses in this way, it was possible to compare the two groups as shown in Table 24.

Nurses who demonstrated the need to find meaning and purpose in their own lives seemed to identify non-religious needs whereas

<p style="text-align: center;"><u>TABLE 24</u>  <u>TYPE OF SPIRITUAL NEEDS IDENTIFIED AND CARE GIVEN BY NURSES IN</u>  <u>RELATION TO THEIR PERSONAL SEARCH FOR MEANING</u></p>												
	Search for meaning						No search for meaning					
Subject No.	1	2	3	4	5	6	1	2	3	4	5	6
Type of needs identified	1+2	2	2	1+2	2	2	1+2	1	1	1+2	1+2	1+2
Level at which needs recognised	ab	b	b	ab	ab	b	a	a	ab	ab	a	b
Level of response	o	mo	mo	mo	mno	n	m	mn	m	mno	mo	mo
Level of evaluation	yz	yz	xyz	xyz	xyz	z	y	y	xyz	xyz	xy	xyz
<u>KEY</u> as in Table 23												

those who did not display this characteristic appeared to identify mainly religious needs or both types of needs. The former group, however, seemed to respond and evaluate at a deeper level than the latter group.

It would seem, therefore, that although nurses who demonstrated no personal need to find meaning in their lives appeared to identify a wider variety of spiritual needs than those demonstrating this characteristic, the latter group seemed to give spiritual care at the deepest level.

#### 2.4.3 Nurses' perceptions of spiritual need and spiritual care

It seemed that the type of spiritual needs nurses identified and the care they gave corresponded with their perceptions of these terms e.g nurses who defined spiritual need in religious and broader terms would identify both types of need in practice and those who considered it the nurse's role to respond to both types of need in practice would do so.

In order to explore this observation, nurses' definitions of spiritual need and spiritual care were compared with the spiritual needs they identified and the responses they gave respectively. The results are presented in Table 25.

As shown in Table 25, the spiritual needs identified and the care given by nurses seemed, on the whole, to correspond with their definitions of these terms. However, the needs identified and care given by nurses may ultimately be more connected with the spiritual needs the nurse herself had experienced and the extent to which she had come to terms with certain spiritual issues e.g death, dying. Her personal experience may trace back eventually to her fundamental beliefs about life, death, her life experience and the extent to which she was self-actualised.

In conclusion, within the sample, it appeared that the belief system of the nurse, her personal search for meaning and her perception of spiritual need and spiritual care were factors which may have influenced which spiritual needs she recognised and the spiritual care she gave.



TABLE 25  
A COMPARISON OF NURSES' DEFINITIONS OF SPIRITUAL NEED AND  
SPIRITUAL CARE WITH THEIR PROFESSED PRACTICE

Sub- ject No.	Definition of spiritual need	Spiritual needs identified
1	religious	Initially stated had not identified any spiritual needs. Later religious : to practise religion
2	religious + non-religious	Initially stated had not identified any spiritual needs. Later religious: for priest prior to death, to pray
3	religious	Initially stated had not identified any spiritual needs. Later religious: for mass
4	religious + non-religious	Religious: for communion Non-religious: for love
5	religious + non-religious	Religious: for reassurance that going to heaven Non-religious: relief from fear of dying
6	religious + non-religious	Non-religious: to be prepared for death
7	religious + non-religious	Religious: to see Rabbi Non-religious: for love
8	religious + non-religious + deeper God related	Non-religious: for peace
9	religious + deeper God related	Deeper God related: to put things right with God Non-religious: to be prepared for death
10	religious + non-religious + deeper God related	Religious: for sacraments Non-religious: to be known Deeper God related: for reconciliation with God
11	religious + non-religious + deeper God related	Non-religious: to come to terms with death
12	religious + deeper God related	Non-religious: to be free from fear

Sub- ject No.	Definition of spiritual care	Response to patients' spiritual needs
1	Don't know.	Allowed religious representative access
2	To recognise a spiritual need and refer	Recognised need and contacted clergy
3	Care given by clergy	Contacted clergy
4	To refer with religious needs + respond personally to non-religious needs	Referred religious needs + issue concerning need for forgiveness. Responded personally to other needs e.g showed love by giving good care
5	To refer with some religious rituals + respond personally with some religious and non-religious needs	Responded personally to religious needs e.g read Bible, pray with patient + non-religious needs e.g "being with" patient
6	To refer with religious needs + respond personally to non-religious + some religious needs	Referred needs related to death and the after-life that had not come to terms with herself. Responded personally with some issues concerning death e.g talked with patient about religion + non-religious issues
7	To refer with religious needs + respond personally to non-religious needs	Referred religious issues e.g contacted Rabbi + helped with non-religious needs e.g showed love through touch
8	To respond personally to non-religious + deeper God related needs + refer with rituals	Responded to non-religious needs e.g "being with" patient
9	To respond personally to some religious needs + refer with others	Responded to non-religious needs e.g listened + referred religious needs
10	To respond to all needs except some religious rituals	Responded to: deeper God related needs e.g shared own experiences of God; non-religious needs e.g listened and gave hope. Referred sacraments

Sub- ject No.	Definition of spiritual care	Response to patients' spiritual needs
11	To respond to all needs except some religious rituals	Responded to non-religious needs e.g "being with", prayed with patient
12	To respond to all needs except some religious rituals	Responded to non-religious needs e.g listened

## 2.5 EXPLORATION OF THE CHARACTERISTICS OF NURSES IN RELATION TO THE LEVEL OF SPIRITUAL CARE GIVEN

An alternative measure employed to identify factors which may have influenced the spiritual care given by nurses was to look at the characteristics displayed by those who consistently gave spiritual care either at a deep or a superficial level. These are discussed in turn below. In addition, demographic information about each respondent is given. It was felt that any differences in characteristics identified between the two groups may point to factors which could have influenced how spiritual care was given. Again researcher bias was acknowledged in the analysis.

### Characteristics of nurses who gave the most comprehensive spiritual care

Nurses were considered to have given the most comprehensive spiritual care if in every example cited by them they recognised, responded and evaluated at the deepest level.

Four nurses had given care in this way. The transcripts of their interviews were re-read and the following common characteristics were noted. All comments refer to the four nurses.

1     They seemed to be particularly sensitive/perceptive

This is demonstrated by the following examples of comments they made:

Nurse 1.   S/N, Single, 20-29 yrs old, 6-10 yrs experience  
             long term care ward, Dumfries & Galloway, R/C

"...its like when you say spiritual I can feel it. I can't explain it...but I can feel it..."

"...it's like an unseen bond between her and her daughter...something in her daughter just isn't right...I really can't explain it...I can actually feel that she's not satisfied but I can't explain to you what it is that's missing..."

Nurse 2   C/N, Single, 20-29 yrs old, 6-10 yrs experience, long  
             term care, Argyll & Clyde, C/S

"I knew she was going to die quite a wee while before anyone else suspected it. I thought she's not going to come out of this."

"...it wasn't anything she said...attitudes. I think it was more her face actually....her eyes...very expressive eyes...mirroring what's going on...sometimes she'd put out her hand...and take hold of my hand...you got a transfer."

"...there's a kind of radiation comes from people...if you touch them you can feel the life force going through the body...many's a time I've taken somebody's BP and pulse...been within normal parameters and I have questioned the vitality of that individual...and ultimately something has happened to prove me right."

" (speaking of her daughter who had anorexia)...this particular night...she was lying next to me...I could feel the life force that was dominant in me and not in her...I thought is there no way I can transfer some of this from me to her...I began to really think about it and will it to happen...I felt a tingling along the parts of my body that were in contact with her...after that there was a subtle difference in her

condition...you felt her energy levels rising and within a relatively short time...she went and picked up an apple and began to eat it."

Nurse 3 S/N, married, 30-39 yrs old, 11-25 yrs experience, varied ward, Argyll and Clyde, R/C

"I would say it was more than that...the spark within her was probably kindled..."

"...she was unhappy...her facial expression, her conversation...the necessity for alcohol...I believe she wanted an escape from reality if you will..."

"At that time I felt her spirit needed fed."

"Hopefully we're giving them a tomorrow to look forward to...what is typically seen in bad geriatric care are little faces that have no tomorrow and some of them will even wish they had no tomorrow...showing that you can identify to their true selves...a smile...it's almost as if the person inside there is saying thank you you understand..."

Nurse 4 S/N, widow, 50-59 yrs old, 11-25 yrs experience, long term care, Lothian, C/S, beginning psychiatric training

"...sometimes if they're very uneasy and just unhappy in themselves..."

" I hope mental training will help with this to learn to really listen to what they're saying inside as much as outside..."

## 2 They demonstrated an awareness of the spiritual dimension in everyday living

These nurses seemed to be deeply aware of the spiritual dimension in their daily lives and appeared to have thought it through. This was indicated by the fact that they had alot to say on the

subject and related the spiritual dimension to all aspects of life e.g world events, re-incarnation, death and dying, psychopaths, appreciation of scenery.

3     **They demonstrated an awareness of God who was in ultimate control of their existence**

Although not necessarily religious, these nurses seemed to be aware of God as illustrated in the following extracts taken from the transcripts:

Nurse 1

"...because I have some belief myself I maybe just find it difficult to believe that somebody has absolutely no belief in anything."

"...I believe in a soul...we've all got a soul...although you could have a psychological need met...it may not have reached your soul..."

Nurse 2

"...what I understand with the real core meaning of spirituality is a need for a higher spiritual presence than man or any other living creature...it basically arises from a source within us, the soul if you want to call it that...there is something deep within the core of every individual."

"I'm not a member of a particular religious group...if I was going to describe myself...certainly not an atheist and I don't think agnostic really fits me...there's something missing with all the ...religious dogma..."

"...if you didn't have any spirituality yourself how could you possibly get on to the same wavelength...it's all to do with wavelength..."

### Nurse 3

"If I hadn't been a Christian nurse...the situation may have gone unnoticed...(it was) significant for me because I'm a Christian...my child had just made her first Holy Communion...and I showed photographs to the patient who said to me 'well of course that's not part of my life any more'...of course immediately as a Christian I had to say to her that everyone was deserving...you may feel at the time there was an intervention of the Holy Spirit..."

### Nurse 4

"I think God is a being whom we can know personally...I think too life after death is a very definite thing..."

"I would say that the whole of our being is a spiritual need...the whole of life is related to God"

## **4 They appeared willing to give of themselves to others**

These nurses were actively involved in helping patients with their spiritual needs at a deep personal level themselves, as illustrated by the following extracts from the transcripts:

### Nurse 1

"It's a physical thing as well....I strongly believe in physical contact...reassurance might only be holding someone's hand...giving them a cuddle...just being there ...sitting and talking..."

"...what you believe and what they believe might be totally incompatible...you don't have to be of the same religion to provide them with the reassurance they want. As long as you're not frightened to speak to them about it."

### Nurse 2

"...when she did die I called out the doctor and I said to him...'in the bad old days of nursing someone would have been found to sit with that patient' and he said



'oh but she wasn't aware' I said 'well we don't actually know that whether she was aware or not I feel strongly that no-one should die alone in a hospital"

"...my sister is actually dying at the moment of a malignant brain tumour...when I speak to her I don't know if they've done this or not (tell her her diagnosis)...it makes it very difficult for me...I would like to be able to...sit with her and talk it through...want to be honest with her...I want to talk to her on a deeper emotional plane and I just can't"

#### Nurse 3

"...it's something that you feel is personal to yourself and to a relationship with yourself and your patient... it's something you're aware that you are giving different patients. You know that you have something to offer the patient at that particular level...it's targeting the self of a person...it's seeing them as absolutely unique..."

"(talking of her relationship with the patient)...this is what I represent and anything that that represents I'm here to give you...(regardless of my) circumstances...I am the nurse for you..."

#### Nurse 4

"I would feel able to be me with that person...inside I would be praying...sometimes I have a little booklet...I think you have to be sensitive...I do consciously commit them to God as often as I can..."

- 5     They appeared to be searching for meaning and purpose in their own lives

This characteristic is illustrated in the following extracts:

#### Nurse 1

"...I feel sometimes...I maybe don't have strong beliefs myself...I perhaps don't believe that life probably ends when you die. I think life as we know it does but I'm not sure..."

" (talking of the need for reassurance and guidance)...I think it comes sporadically in life...it's not always when something terrible is happening...you might be the same as you were physically 6 weeks ago but emotionally you're on a low..."

#### Nurse 2

"...you might start with a particular ideology...then towards the end of your life you realise there is a gap - I feel it myself...we all have this need that there is somebody up there who's got the answer to the whole complex issues that we all face..."

\* "... (speaking of her sister who was dying) explore what might be ahead for both of us...I'm 57...nobody knows how long they've got...you begin to think a wee bit more deeply about what's maybe on the other side..."

#### Nurse 3

"...perhaps she was led to her spiritual awakening through this very difficult physical situation..."

"...I like reading it (philosophy)...I pick it up and I read it and say that's marvellous..fascinating..fabulous ideas..."

#### Nurse 4

"..they're very deep thoughtful questions (asked at interview)...it'll make me think for years."

"...he (God) can give us a whole purpose in living and a whole purpose in what we're doing and relationships with other people...He can meet our need for forgiveness...freedom from guilt..."

\* insert here

#### **6 They shared of life experiences and what they had learned from these**

Throughout the interviews these nurses made constant reference to personal life events such as crises and shared what they had learned from these experiences. Examples of this are given below:

Nurse 1

"...I tended to look back through my nursing career and I think...I'm much better prepared...I think my patients have prepared me...I think because...I've gone through bereavement...more than I had when I was even 10 years ago when I was 20. There's been alot more bereavement in the family and all the rest of it and I've coped with it. If you're helping relatives it's easier to know what they want...you've been through the process...you know what they're going through...you're better prepared for facing the people that you're going to be helping through it..."

"...I expect the clergy to have stronger beliefs than I do...I may not be so reticent to do that in the future...because I feel I know more about it...I'm more experienced..."

Nurse 2

"...(speaking of patient who was dying) I don't know if I could say empathy because I've never actually been dying...I tried to feel as much understanding as I could considering I hadn't actually been in the situation myself..."

✕ "...I know how I feel since my husband died...the lack of the physical presence of another human being...leaves a big gap...just the feeling that there is another person that cares enough about you with a l l y o u r failings, to sit with you..."

Nurse 3

(when asked if she would feel able to personally help a patient of a different faith) "...well in my instance having married a Hindu it would present no difficulty at all."

Nurse 4

"...you knew what they were feeling...my husband died suddenly so in that sense...you just seem to appreciate what she was going through..."

K Insert here

### Characteristics of nurses who gave the most superficial spiritual care

It was considered that nurses had given the most superficial spiritual care if they did not recognise and respond or evaluate at the deepest level in any patient examples cited by them. Two nurses gave care in this way. Following examination of their transcripts, they appeared to demonstrate the following characteristics.

- 1     They did not seem notably sensitive/perceptive to patients' spiritual needs

This was the general impression given by statements similar to the following:

Nurse 1   S/N, married, 21-29 yrs old, <1 yr in practice, long term care, Dumfries & Galloway, no religious affiliation

"We ask them their religion...but it doesn't go much further than that...you step back..."

"It would be up to them really to let you in...they wanted certain surroundings...privacy...certain people there and they got that but I don't know about their...needs...the rest was up to them..."

Nurse 2   C/N, married, over 60 yrs of age, over 26 yrs experience, long term care, Argyll & Clyde, C/S

(when asked if she thought some nurses could give spiritual care)... "Oh aye there's lots. I'm sure there are and do it"

(when asked if she considered herself in that category)  
"I don't know, I'd do anything a patient asked me to..."

- 2     They did not seem to have much idea about or to have given much thought to the spiritual dimension before

This was indicated by the following examples of statements made by them:

Nurse 1

"I really am not a very religious person myself so it would be a subject I wouldn't know what I was talking about really...how can I say anybody has or hasn't got spiritual needs."

"It's maybe people...look for reassurance that they don't think anybody else can give them...a magical sort of untouchable sort...something with more importance to it..." when asked what the thing with more importance was "...I don't know. A power, I can't describe it...I just don't see it as part of our work...what spiritual care can nurses give I mean we care for them physically and mentally...I just can't see that we can..."

Nurse 2

"I had to read it over and over again (the questionnaire) and then I brought it home."

When asked what spiritual needs patients might have "...well I'm sure most people say 'God help me' or I don't know I'm probably on the wrong track...I feel that they'd have to have friends...they would need some help but I don't know what type...I don't know..."

- 3     They considered their beliefs to be a private and personal matter

Statements made by nurses which alerted the researcher to the fact that they considered their beliefs a private matter were:

Nurse 1

"...it's something too personal...I feel you're going into ground that you've got no right to be in...I would hate anybody....wanting to get that close to me...I'm a very guarded person..."

Nurse 2

"I believe in God...I haven't been to church for a few years..."

"...at first I thought it's really a private sort of thing...to discuss anything like that with a patient."

- 4     They seemed reluctant to share of themselves at a deep level when giving spiritual care

The above characteristic is captured in the following extracts:

Nurse 1

" (talking of meeting of patients' spiritual needs)...they might go to their family...people close to them...members of their religion but I don't think we're that close...I don't think we should get that close...I think it's too personal...if you get that close you get too involved...maybe I observe from a distance.." When asked if the nurse could be involved in spiritual care "...well if she felt she could...help...that's fair enough but I personally don't...you should be your own motivator, if you want to do it you should do it. I don't think it should be taught. I don't think you could."

Nurse 2

"..I felt I couldn't give a lot of spiritual need to a patient except through the clergy..."

- 5     They did not appear to demonstrate a personal search for meaning and purpose in their own lives

Nurse 2 gave no indication at any point in the interview of a personal search for meaning in her life. Nurse 1 acknowledged that life must have meaning but appeared unsure about it as indicated by her statement:

"There's a meaning in life...there must be motivation of some sort...I really don't know. It's just something I really don't know anything about..."

- 6     They did not share any life experiences from which they had learned

Nurse 1 said she felt spiritual needs would arise in crisis but gave no personal examples of crisis in her own life. When asked if she had ever contacted the clergy on behalf of a patient she replied:

"No...I've never been involved with that."

Nurse 2 said she felt guilty about not going to church and about not having spent time with her mother before she died. She dealt with her guilt by asking God to forgive her and would not have felt comfortable talking to the minister or anyone else about it. Thus her actions were in keeping with her belief system i.e that this was a private and personal matter.

In conclusion, it would appear, from the limited number of nurses studied, that the following characteristics of nurses were conducive to the giving of spiritual care at a deep level:

- o awareness of the spiritual dimension in everyday living
- o awareness of God
- o personal search for meaning and purpose in life
- o having experience and learned from life events e.g crises
- o willingness to give of self to others
- o sensitivity/perceptivity.

Nurses who gave spiritual care superficially either did not demonstrate the above characteristics or did so to a lesser degree. Nurses who gave spiritual care deeply or superficially varied in their grade, geographical location, type of ward, age, marital status, religious affiliation and length of time in practice. This suggests that the personal characteristics identified in this chapter may be more instrumental in determining the spiritual care nurses give than those previously identified through the cross-tabulation of variables.



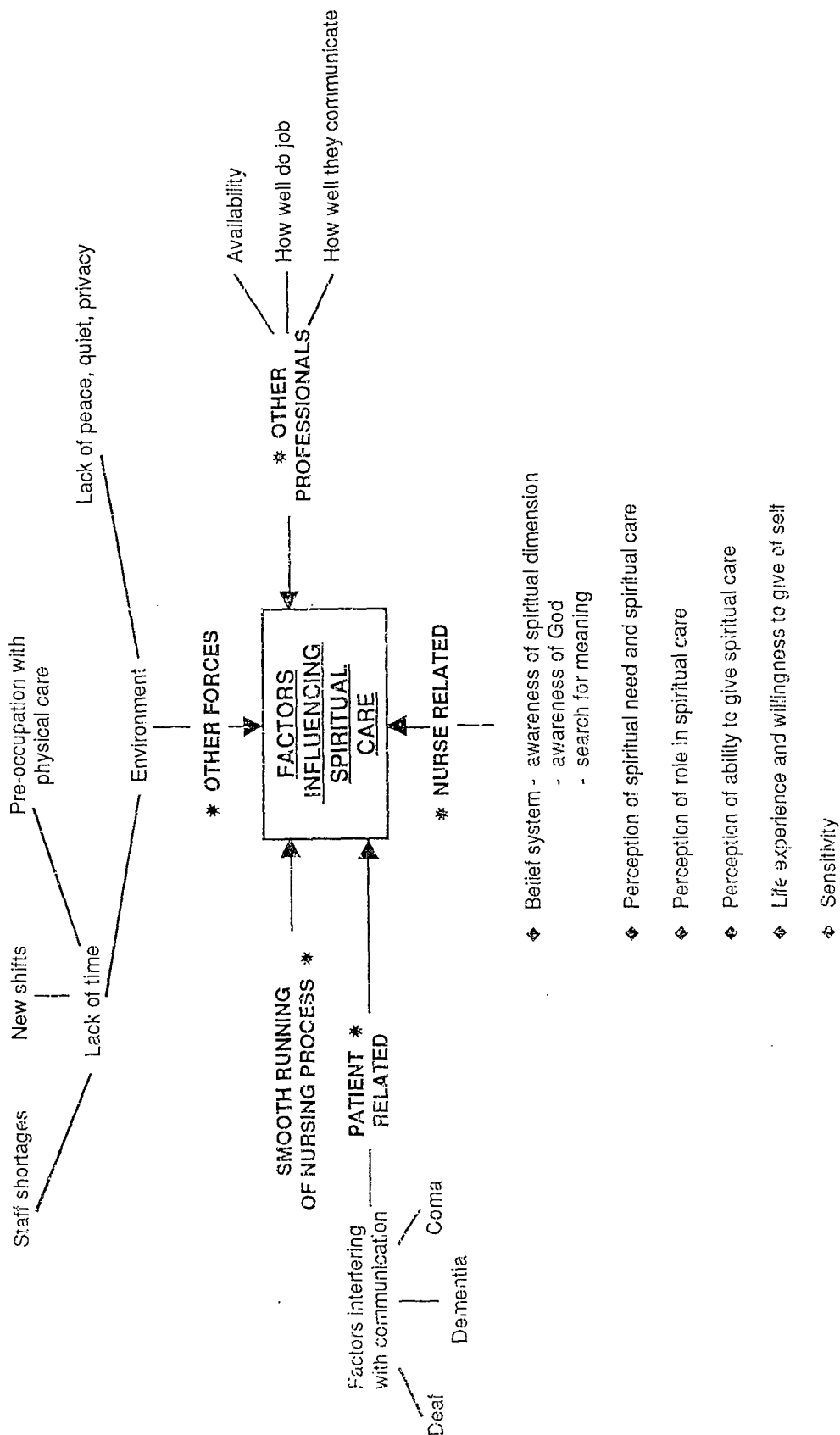
### 3 SUMMARY AND CONCLUSIONS

Although it is not possible to make generalisations from such a small sample, the semi-structured interviews conducted with twelve nurses nevertheless highlighted a number of factors which may have influenced the spiritual care they gave. In addition, the findings provide possible clues as to factors which may have influenced the care given by nurses in the larger sample, although this cannot be assumed.

Five main factors, similar to those identified by Hockey (1979) (Figure 9), appeared to influence the spiritual care that this sample of nurses gave and are summarised in Figure 28. These were related to the nurse, patient, other professionals, environment and operation of the Nursing Process. Each factor is discussed below.

First, concerning the nurse, it seemed that nurses who demonstrated a personal search for meaning in their own lives, although they identified a narrower range of spiritual needs (Section 2.4), gave spiritual care at a deeper level than those who did not demonstrate this characteristic (Sections 2.4, 2.5). As search for meaning is a spiritual concern (Chapter 1), this finding may be directly related to the belief system of the nurse which also seemed to be connected with the spiritual care she

**FIGURE 28**  
**FACTORS, EMERGING FROM THE QUALITATIVE PART OF THE STUDY,**  
**WHICH APPEARED TO INFLUENCE SPIRITUAL CARE**



gave. The belief system of the nurse was similarly identified in other studies as a factor influencing the general care (Forrest 1989, Samarel 1991) and spiritual care (Piles 1986) nurses gave.

Initially it appeared that nurses who claimed religious affiliation were better able to identify patients' spiritual needs than those who did not (Chapter 4, Section 3.3). The interviews revealed, however, that the nurse's personal awareness of the spiritual dimension and of God, regardless of whether these were expressed through religious means, may have been more important in determining the spiritual care she gave. This is illustrated by the fact that nurses who demonstrated these characteristics (Sections 2.2, 2.4, 2.5), identified a broad range of spiritual needs (Section 2.4) and gave spiritual care at a deep level (Sections 2.4, 2.5), whereas those who showed limited awareness of the spiritual dimension (Sections 2.2, 2.3, 2.5) and were unsure of their beliefs (Sections 2.2, 2.4) found it difficult to give spiritual care.

Statistical analysis in Chapter 4 (Section 3.3) revealed that C/N's identified more spiritual needs than S/N's. It was suggested that nurses who had gone through certain life experiences and hence were more mature, may have been better able to identify patients' spiritual needs than those who were less mature. The finding from the interviews suggests that the maturity/life experience factor is perhaps more important than

the grade of the nurse in determining the spiritual care given, however, this could not be explained by the fact that C/N's were older or more clinically experienced.

For instance, nurses seemed to be able to personally respond to spiritual needs which they had themselves encountered (Sections 2.2, 2.3, 2.5). This may explain why they seemed to identify spiritual needs and give spiritual care in keeping with their perceptions of these terms (Section 2.4) and why some nurses were willing to be personally involved in giving spiritual care whereas others felt inadequate in this respect (Sections 2.2, 2.3). In a similar vein, Forrest (1989) found that the nurse's own experience affected her caring and Samarel (1991) reported how nurses who had personally come to terms with death were able to help terminally ill patients.

Furthermore, the nurse's perception of her role appeared to influence the care she gave e.g nurses who did not consider spiritual care their duty did not give it (Section 2.2). This is consistent with the findings of Highfield and Cason (1983), Hitchens (1988) and Piles (1986). In a similar vein, Forrest (1989) found that the nurse's own experience affected her caring and Samarel (1991) reported how nurses who had personally come to terms with death were able to help terminally ill patients. Moreover, the nature of the nurse appeared to influence the spiritual care she gave (Section 2.2) in that those nurses who

were particularly sensitive people seemed to identify the broadest range of spiritual needs and give spiritual care at the deepest level (Section 2.5).

Additionally, the nurse's grade and the type of ward and geographical area in which she was working, (factors found to be associated with the identification of spiritual needs by nurses in Chapter 4), did not seem to affect the level of spiritual care she gave (Section 2.5). This further supports the suggestion that the personal characteristics of the nurse are perhaps more important than these other factors in determining the spiritual care given. The influence of grade, ward type and geographical location in the giving of spiritual care cannot be ruled out, however; further research would be required to ascertain this and to determine if any of the reasons offered by nurses as possible explanations (Section 2.1) were valid.

Second, the nature of the patient's condition seemed to influence the spiritual care nurses gave. It seemed to make it difficult for nurses to give spiritual care if patients were demented, deaf, comatosed (Sections 2.2, 2.3) or unresponsive for whatever other reason (Section 2.1). This was similarly borne out by Samarel's (1991) study and may explain why nurses working on non-varied wards reported identifying fewer spiritual needs than those on varied wards (Chapter 4, Section 3.3).

Third, the unavailability of, inadequate care given by and lack of communication with other professionals such as clergy (Section 2.2) and environmental factors such as lack of time, peace, quiet and privacy were factors nurses stated interfered with them giving spiritual care (Sections 2.2, 2.3). Lack of time was also a factor identified by other researchers which interfered with the giving of care in general (Forrest 1991, Samarel 1991) and with spiritual care in particular (Piles 1986).

Finally, in more general terms, it appeared from exploring with nurses the spiritual care they gave, that none applied the Nursing Process to spiritual care and that any factor which interfered with the smooth running of this process (Figure 8) delayed or prevented effective spiritual care from being given (Section 2.3).

## CHAPTER 6

## CONCLUSIONS

The purpose of this chapter is to give an overview of the study and its main findings before discussing their implications. Tentative suggestions for nursing practice are then given and topics for further research are proposed.

## 1 OVERVIEW OF THE STUDY

Having illustrated that the spiritual dimension can influence health, well-being and quality of life (Chapter 1, Section 1), it was shown that spiritual care should be part of the nurse's role (Chapter 1, Section 3). However, guidelines for its practice were absent in the nursing literature and nothing was known about how British nurses perceived their role in this aspect of care (Chapter 1, Section 4).

A conceptual framework for giving spiritual care based on the Nursing Process was, therefore, proposed by the author (Chapter 2). It was recognised, however, that there is currently a lack of knowledge to enable the conceptual framework to be enacted and furthermore it would require to be tested. As outlined in Chapter 3, the study aims were twofold and a dual approach, which blended both quantitative (Chapter 4) and qualitative (Chapter 5) methods was adopted to address these aims. Every method has its pros and cons thus use of a dual approach limited the study in a number of ways.



Perhaps one of the study's main weaknesses lies in the fact that the sample of nurses responding (n=685) may not have been representative of the population (n=1170). In addition not all Health Boards were included. It cannot be assumed, therefore, that the way in which the sample of nurses stated they perceived spiritual need and spiritual care and gave this care in practice, was indicative of the population, or the same group of nurses working in Scotland as a whole or any other part of the country. Additionally, the findings relate only to nurses working on care of the elderly wards. There is suggestion that spiritual needs may be more ~~obvious~~ in acute settings (Chapter 4, Section 3.3), however further research would be required to ascertain this. The findings cannot, therefore, be generalised to nurses working in settings other than care of the elderly. Moreover, it was assumed that what nurses said they did was what they actually did, however this may not have been the case.

The sample of nurses from which information was obtained with regard to factors influencing spiritual care was very small (n=12) and selected on the basis of set criteria. It cannot be assumed therefore that the factors identified as apparently influential in the giving of spiritual care were the same for the larger sample (n=685), the population or any other group.

Finally, although measures were employed to minimise its effects, the study is further limited by researcher bias. This is acknowledged particularly in relation to the categorisation of responses to open questions, selection of the sample for interviews and in the analysis of the transcripts.

Given the above limitations, the results, a synopsis of which is now given, can only be taken as indicative of the sample.

The first part of the study described how 685 nurses working in care of the elderly settings in twelve Health Boards in Scotland perceived spiritual need and spiritual care and how they gave this care (Chapter 4, Section 3.2). The majority of nurses said they had identified a spiritual need at some point in their practice. Collectively as a group they perceived the concept in terms of the individual's need for: belief and faith; for peace and comfort; to give and receive love and forgiveness; for meaning, purpose and fulfilment; for hope and creativity. They had a propensity, however, to view spiritual need in religious terms. They recognised patients' spiritual needs mainly through non-verbal/indirect verbal cues patients displayed.

Although the majority of nurses considered it their shared responsibility to respond to patients' spiritual needs and some did so personally, over half preferred to refer them to others, mainly the clergy, possibly because they felt inadequate about personally responding.

Most nurses evaluated the care which had been given positively and did so through observing non-verbal/indirect verbal cues patients displayed. As Table 13 shows, the cues nurses used in evaluating were the opposite of those which had alerted them to patients' needs (Table 11).

In the second part of the study a variety of analyses were employed and five factors, similar to those cited by Hockey (1989) (Figure 9), were identified which appeared to influence the spiritual care nurses gave (Chapter 4, Section 3.3 and Chapter 5). These related to the nurse, patient, other professionals, environment and smooth running of the Nursing Process.

Statistical analysis in the larger sample (n=685) revealed that Charge Nurses claiming religious affiliation seemed better able to identify patients' spiritual needs than Staff Nurses who claimed none (Chapter 4). Based on the smaller sample (n=12), more in-depth analysis suggested that, rather than grade and religious affiliation, personal characteristics of the nurse were perhaps more important in determining their giving of spiritual care. Although further research would be required to clarify this it seemed that nurses who demonstrated 1) an awareness of the spiritual dimension in their own lives 2) were personally searching for meaning 3) had experienced crises 4) perceived spiritual care as part of their role and 5) were particularly sensitive/perceptive people, were able to identify a broader

range of spiritual needs and give spiritual care at a deeper level than those who did not demonstrate these characteristics (Chapter 5).

Second, any factors in the patient's condition which interfered with nurse-patient communication seemed to make it difficult for nurses to identify spiritual needs and give spiritual care (Chapter 4, Section 3.3 and Chapter 5).

Also, the unavailability of, inadequate care given by and lack of communication with other professionals, particularly the clergy, together with environmental factors such as lack of time, peace, quiet and privacy seemed to hinder some nurses from giving spiritual care (Chapter 4, Section 3.3 and Chapter 5).

Concerning environmental factors, although explanations were suggested for the association between ward type and the identification of spiritual needs by nurses in the larger sample, none could be offered for the association of the latter with the geographical location of nurses (Chapter 4, Section 3.3).

Finally, it was suggested in Chapter 2 that the best way of ensuring that patients' spiritual needs were met was by giving care systematically using the Nursing Process. From the smaller sample (n=12), there was evidence to suggest that the Nursing Process may not be applied to spiritual care (Chapter 5), and that any of the above mentioned factors could interfere with the smooth running of that process.

As discussed above, because of the nature of the study, the findings cannot be generalised, their implications can only be tentative and suggestions rather than recommendations for practice only can be given. These are discussed below.

## 2 IMPLICATIONS

Although the majority of nurses seemed able to identify patients' spiritual needs, on closer scrutiny they may have performed this function less well than the results of the study indicate.

First it was not possible to ascertain to what extent they had identified patients' spiritual needs.

Second, as suggested in Chapter 4 (Section 3.2.2), the proportion of nurses considering spiritual care not part of their role may have been higher in the population than the results of the study indicated.

Third, the fact that nurses seemed to define spiritual need in religious terms, together with the fact that the smaller sample seemed to identify spiritual needs and give care in keeping with their perceptions of these terms, implies that patients' religious needs may be more readily identified than other spiritual needs they may have or that spiritual needs are most commonly expressed in religious terms. Also, if nurses considered spiritual and psychological needs to be synonymous,

they may ignore spiritual interventions in helping patients who were, for instance, struggling to find meaning in their illness. Furthermore, there was suggestion that the identification of patients' spiritual needs may depend on the sensitivity of the nurse. The implications of these findings are that for some patients all/some of their spiritual needs may go unrecognised or may be inadequately or inappropriately dealt with thus hindering them from attaining an optimum level of spiritual well-being and overall state of health, the importance of which is illustrated in Figure 7.

Whether they did not consider spiritual care part of their role or felt inadequate about giving it, the fact that, in general, nurses did not feel personally able to respond to patients' spiritual needs implies that patients may have experienced delay in having these needs met or that their needs may not have been met at all, or only partially met e.g in the case of referral. Referral in itself may not be detrimental to ensuring that action is taken to meet patients' spiritual needs as ultimately what matters is that patients' needs are met. However, in the real world the referral process, whether to other nurses, clergy or others, may not operate efficiently and may therefore interrupt the Nursing Process resulting in delay/prevention of patients' having their spiritual needs met. This may happen for a number of reasons as outlined in Figure 29. It should be noted that the situation described in the figure is not as clear cut as it

FIGURE 29  
POSSIBLE PITFALLS OF REFERRING PATIENTS' SPIRITUAL NEEDS TO  
OTHERS

<u>Stage of Nursing Process</u>	<u>The referral process operating efficiently</u>	<u>Ways in which referral process could be prevented from operating efficiently</u>
<p>Assessment ↓ Planning + Intervention</p> <p>↓</p> <p>Evaluation</p>	<p>Identification of spiritual need by nurse ↓ Responds by contacting nurse, clergy or other (person)</p> <p>↓</p> <p>Person available</p> <p>↓</p> <p>Comes to see patient</p> <p>↓</p> <p>Responds to patient's need</p> <p>↓</p> <p>Spiritual need met</p>	<p>Person may not be contacted if:</p> <ul style="list-style-type: none"> <li>- there is a breakdown in communication between nurses on different shifts fostered by lack of documentation. The findings of the interviews highlighted this as a problem as did O'Neill (1984)</li> <li>- if information passed on by one nurse is not enacted by another because she perhaps does not consider it a priority. Both Hitchens (1988) and Piles (1986) found that whether or not and how spiritual care was practised depended on the degree to which it was valued by the nurse</li> <li>- the chores of the day take over or there is pre-occupation with physical care, as found by Highfield and Cason (1983)</li> <li>- a spiritual need becomes evident during the night which may not be considered urgent enough to necessitate referring right away.</li> </ul> <p>↓</p> <p>Person available</p> <ul style="list-style-type: none"> <li>- may not be available. For instance the chaplain is one person usually responsible for hundreds of patients and/or several hospitals (Flesner 1981), therefore they will not always be available when needed.</li> </ul> <p>↓</p> <p>Comes to see patient</p> <ul style="list-style-type: none"> <li>- May not be able to call to see patient or may be delayed.</li> </ul> <p>↓</p> <p>Responds to patient's need</p> <ul style="list-style-type: none"> <li>- If person comes and responds to the patient's spiritual need, this response could be ineffective if, for example they are late or the action taken failed to meet the need.</li> </ul> <p>↓</p> <p>Spiritual need not met/partially met.</p>

appears but is presented in this way for illustration purposes. Furthermore, even if the referral process operated smoothly, it would still introduce discontinuity of care.

On the whole, nurses considered the spiritual care given to have been effective and reached this conclusion through re-assessing the patient's condition. Some nurses, however, made this assumption on the basis that an event had occurred e.g the minister had visited. In such cases it is possible that the patient's need may not have been met but, because the nurse assumed it had been met, alternative interventions may not have been instigated.

The expectation is that the broader the range of spiritual needs nurses can identify and respond to at the deepest level, the more likely patients' spiritual needs will be met and an optimum level of total health, well-being and quality of life facilitated (Figure 26). It would appear, therefore, that nurses who were themselves spiritually aware, were personally searching for meaning in life; had experienced crises; perceived spiritual care as part of their role and were particularly sensitive/perceptive people, would be best able to operate in this way. This implies, however, that patients being cared for by nurses not in possession of these qualities may not have their spiritual needs well attended to. It also raises the question as to whether or not all nurses can be expected to identify a broad range of spiritual needs and give spiritual care at a deep level. If not,



perhaps nurses who could would be over burdened. Furthermore whether or not patients' spiritual needs were met would depend on the efficiency of the referral process.

Moreover, the fact that nurses found it difficult to identify spiritual needs in patients suffering from conditions such as dementia, deafness etc implies that it may be difficult for nurses to identify spiritual needs in patients suffering from any conditions interfering with nurse-patient communication. Although the list of such patients is endless examples include those afflicted with: aphasia; dysphasia; loss of affect because of depression, drug therapy, CVA, institutionalisation; confusion, whether induced by drugs, infection or other causes as well as those who are unconscious. The implication is that for all these patients their spiritual needs may not be recognised.

Additionally, patients who are highly physically dependent or situated in wards which are short staffed, noisy, lacking in privacy, which operate new shift patterns or where there is poor collaboration with the clergy, may not have their spiritual needs well attended to.

Finally, as a general but nevertheless important point, it would appear that nurses may not be used to applying the Nursing Process to spiritual care and also that there are many potential factors which could interfere with the smooth running of this process. This could result in discontinuity of care and delay or

prevention in the giving of effective spiritual care. Such an outcome would, therefore, be detrimental to patients who had spiritual needs in that they would be hindered from attaining an optimum level of spiritual and hence overall well-being as discussed in Chapter 1 (Figure 7).

It could be argued that whenever such factors prevent spiritual needs from being recognised, that a situation of nurse induced iatrogenesis (Illich 1975) emerges in that the very state of health which nursing aims to promote is hindered by its own structure and the environment in which it functions. For instance, administrative constraints may mean that nurses do not have the time to give the care they would like.

### 3 SUGGESTIONS FOR PRACTICE

Given the limitations of this descriptive study, firm recommendations for practice are not warranted, therefore, tentative suggestions only are made.

It would appear that if the spiritual needs of patients are to be identified and met and patients are consequently to be assisted to achieve an optimum level of health and well-being it is important that nurses are able to give spiritual care systematically.

There is indication that some nurses need to be made aware that spiritual care is part of their duty, whilst for others their concept of spiritual need requires to be broadened. As stated in the guidelines for nurse education (Chapter 1, Section 3) nurses would probably benefit from some form of teaching on spiritual care in their basic education. However, the way in which spiritual care could best be taught is not clear. Formal teaching could include topics such as description and definition of the spiritual dimension, spiritual needs and spiritual care in the broadest terms; the influence of the spiritual dimension on health and therefore the significance of spiritual care for nursing.

Additionally, although it would not be possible to alter the nurse's life experience and unethical to attempt to change her beliefs, it may be possible to maximise her awareness of patients' spiritual needs and her ability and confidence in giving systematic spiritual care. Furthermore, the fact that all three nurses who had stated in the questionnaire that they had never identified a spiritual need, through discussion at interview became aware of having done so, suggests that it may be possible to teach nurses greater awareness of patients' spiritual needs. This could perhaps be achieved by using self awareness/sensitivity teaching. This was an approach adopted by both Hitchens (1988) and Piles (1986) based on their findings that the most powerful factor determining how nurses gave spiritual care was their personal faith/value system.

Furthermore, Forrest (1989) advocates sensitivity teaching in enabling nurses to care. Self awareness/sensitivity teaching could be conducted in small groups where personal patient encounters or fictitious patient scenarios were explored and analysed with the application of the Nursing Process. Further research would, however, be required to evaluate the effectiveness of these teaching approaches.

Having maximised the potential of the nurse to recognise patients' spiritual needs and give spiritual care, it would appear that there may be some nurses better able to give spiritual care than others. It would be necessary, therefore, to include in any teaching programme the importance of nurses realising their own limitations and knowing when and how to refer with the minimum of disruption to the Nursing Process.

It may be possible to increase the efficiency of the referral process by employing measures to facilitate the application of the Nursing Process to spiritual care. For instance, admission sheets could be altered to include a spiritual assessment and care plans adapted to include space for planning, implementing and evaluating spiritual care. In order to facilitate collaboration between nurses and clergy, it may be beneficial for nurses to: keep a list of the clergy's telephone numbers and "on-call" times; communicate more with the clergy and discuss certain patients with them as they enter and leave the ward; include the clergy in ward planning/patient profile discussions

so that he is treated as a valued member of the health care team. Given the workload of the clergy, the extent of his involvement may, however, be limited.

The findings indicate that even if the nurse's ability to give spiritual care was maximised and the referral process made more efficient that it may still be difficult for nurses to identify the spiritual needs of patients belonging to "high risk" groups i.e those with difficulty in communicating for whatever reason. In some instances patients may simply require more time to enable them to communicate their needs and to be understood. For others e.g the institutionalised, it may be beneficial to attempt to unlock their true self or spirit through creative and interactive therapies such as occupational, reminiscence, art and music therapies, as suggested by Charatan (1991). In all cases collaboration with the patient's family/friends may be indicated in order to ascertain what gave them meaning and hope in their lives prior to deterioration in their condition.

In addition, the nurse may be further hindered from giving spiritual care by the ward environment which may have implications for administrative decisions.

Given the influence of the spiritual dimension on the physical realm, perhaps it would be more economically viable in the long term to ensure that staff had enough time to spend with patients to attend to their spiritual needs. This may involve ensuring

adequate staffing levels are maintained, for example by employing bank/agency nurses if permanent staff are off sick and altering shift patterns to increase rather than reduce staff overlap and/or including the patient's own minister. The result may be production of a higher patient turn over in wards where cure is the desired goal and reduction in demands on staff e.g by the "demanding" patient in wards where care, as opposed to cure, is the main objective. Greater work efficiency and utilisation of resources may, therefore, be outcomes. In such wards it may be possible for time to be set aside as part of the ward routine in order to "be with" rather than "do for" the patient. In these wards adequate staff overlap may be particularly important.

Moreover, it may be possible to "promote" a quiet, peaceful and private "environment in which the...spiritual beliefs of the individual are respected" (ICN 1973, Chapter 1 Section 3) by: having a rest hour as part of the ward routine; having set visiting rather than open visiting; ensuring hospital provision of a chapel or reading/quiet room with no television. Where bed bound patients could not utilise the latter, their beds could be screened to provide privacy.

In conclusion, it would appear that for spiritual care to be given well, many factors require to be present and in the right way. Even in the ideal situation where all the ingredients are present for spiritual care to be given at its best i.e the nurse with the desired qualities and an environment conducive to

spiritual care is provided, there is no guarantee that patients' spiritual needs will be fully met. Perhaps this is because the spirit is not bound to conform to natural laws as the body is. To expect it to do so would be to deny its very nature.

Nightingale (in Henderson and Nite 1978, p15) said that nursing's function is:

"...to put the patient in the best condition for  
nature to act upon him..."

The function of the nurse in spiritual care could be considered to involve putting the patient in the best condition for the spiritual realm to act upon him. Perhaps as nurses we can do no more but, it could be argued, no less than this. Clearly further research is required to provide nurses with the necessary guidelines to enable them to function in this way and in so doing enable them to fulfil their obligation to:

- o promote spiritual health and alleviate spiritual suffering  
(ICN 1973)

- o assist the individual to perform those activities  
contributing to spiritual health that they would have  
performed unaided had they been able (Henderson 1977).

#### 4 SUGGESTIONS FOR FURTHER RESEARCH

One of the limitations of the study noted in this chapter was the inability to generalise the study findings. It would be appropriate, therefore, to replicate the study in other areas of care outwith care of the elderly to see if nurses working in these settings viewed spiritual care similarly or differently to nurses in this study.

The factors identified which appeared to influence the spiritual care nurses in this study gave were merely tentative, therefore, further research would be required to explore this. If the findings were similar this could highlight ways in which excellence in spiritual care could be promoted and, therefore, patients helped to attain an optimum level of well-being, which is the ultimate goal of nursing.

In addition to looking at the nurse's perspective, it would also be appropriate to determine, in care of the elderly and other settings, what patients considered their spiritual needs to be and how they felt they could best be helped to meet these needs. This information would help in the planning of appropriate spiritual care. Studies which looked at both the nurse's and patient's perspectives would indicate the extent to which nurses identify and respond to patients' spiritual needs. Such studies may, therefore, highlight any areas nurses had difficulty in dealing with and thus where further instruction might be



indicated. Such combined studies might also go some way to establishing a generally agreed definition of spiritual need and indicators of spiritual distress and spiritual well-being, all of which, according to the literature reviewed, were lacking (Chapters 1 and 2).

As highlighted in Chapter 2, this information would assist in facilitating the giving of spiritual care using the Nursing Process. A number of possible factors were, however, identified which appeared to interfere with the giving of spiritual care in this way. Further research would be beneficial to identify, more reliably, factors contributing to the fragmentation of care and would, thereby, highlight ways in which continuity of spiritual care could be promoted.

Based on a small sample of nurses it seemed that spiritual care was not included or recorded in patients' care plans, however, further research would be necessary to investigate this in a larger sample. Attention could then focus on exploring ways in which spiritual care could best be incorporated into patients' care plans and hence spiritual care be given systematically.

It emerged from the literature review (Chapter 1, Section 1), this (Chapter 4, Section 3) and other studies (Chapter 1, Section 4), that religious needs were an important aspect of spiritual

care. If found to be the case in future research, it may be beneficial to explore hospitals' provision for patients' religious needs.

Finally the literature review highlighted that spiritual care is expected of nurses and should be taught (Chapter 1, Section 3). However, from interviewing a small sample of nurses and corresponding with educational establishments, it did not appear that spiritual care was taught to any great extent or in any structured way. Additional research could be undertaken on a larger scale to ascertain if and how spiritual care is currently taught to nurses and then to determine how it could best be taught.

## 5 CONCLUDING REMARKS

Returning to the initial aims of the study the author has described how nurses perceived spiritual need and spiritual care and how they reported to have given this care. In addition, factors which appeared to influence the spiritual care nurses gave were identified.

In conclusion, the author has learned much from conducting this study and hopes that some of the above suggestions for further research are pursued by others so that the knowledge base for spiritual care proliferates. In doing so it is hoped that nurses will be better equipped to care for the "spirit" of their

patients which is the very essence of life. Patients could, thus, be helped to achieve their optimum state of health, well-being and quality of life and in so doing nursing would have fulfilled its ultimate goal.

APPENDIX 1

INDICATORS OF SPIRITUAL DISTRESS AND SPIRITUAL WELL-BEING  
IDENTIFIED IN THE LITERATURE

THE NURSING DIAGNOSIS "SPIRITUAL DISTRESS (DISTRESS OF THE HUMAN SPIRIT)" PRODUCED BY NANDA (Kim et al 1984, p 506-508)

ISSUES

1. Consider that spiritual distress may be an etiology for sleep pattern disturbance.
2. Consider spiritual distress related to forgiveness as a diagnostic label.
  - A. Relationship with God characterised by:
    1. Distance/separation/absence.
    2. Lack of belief.
    3. Uncertainty.
    4. Fear.
  - B. Lack of forgiveness experienced by:
    1. Inability to feel God's forgiveness.
      - a. Feels illness is a punishment for a real or imagined wrongdoing.
      - b. Feels God only forgives if a person has demonstrated worthiness in some way.
      - c. Believes God judges and expects more than what he/she has done.
      - d. Feels God as being judgemental and demanding rather than gracious, loving, kind, and forgiving.
    2. Inability to forgive self.
      - a. Is unable to accept self as is.
      - b. Feels need to reach some level of perfection to be okay.
      - c. Punishes self psychologically or physically for real or imagined wrongdoings.
      - d. Engages in self-blame or, at the other extreme, denies all responsibility for problems.
    3. Inability to forgive others.
      - a. Blames other people or things for circumstances as they are.
      - b. Is unable to see other people or their actions realistically/ objectively.
      - c. Holds on to real or imagined injustices of other people.
      - d. Feelings of being judged by others.
3. Consider spiritual distress related to love as a diagnostic label.
  - A. Relationship with God characterised by :
    1. Distance/separation/absence.
    2. Lack of belief.
    3. Uncertainty.
    4. Fear.
  - B. Lack of loving relationships characterised by:
    1. Lack of a healthy loving relationship with God or a transcendent power.
      - a. Lack of belief in God or a higher power.
      - b. Lack of love in God.

- c. Childlike, immature love of God, dependent type of love (expectations of God to magically take care of problems)
  - d. Feelings of distance or separateness from God.
  - e. Unusual distress during normal trials of life.
2. Lack of healthy self-love.
    - a. Poor self-esteem and self-confidence.
    - b. Inability to realistically accept self as worthwhile individual with strengths and weaknesses.
    - c. Sees mostly weakness in self.
    - d. Demonstrates false pride and selfishness.
    - e. Inability to believe that "I am okay just because God loves me".
    - f. Feels unworthy of love of God or others.
  3. Lack of ability to give and receive love with others.
    - a. Uses and manipulates others to get what is wanted.
    - b. Feels others do not love them as they are, always must be something or something for another to earn his love.
    - c. Is able to love only those who meet his needs.
    - d. Seldom able to experience closeness to another.
  4. Consider spiritual distress related to hope as a diagnostic label.
    - A. Relationship with God characterised by:
      - 1. Distance/separation/absence.
      - 2. Lack of belief.
      - 3. Uncertainty.
    - B. Lack of hope characterised by:
      - 1. Sense that life is overwhelming.
      - 2. Feelings of futility.
      - 3. Feels no one, no higher being, nothing can or will help.
      - 4. Inability to provide self with even the smallest gratification.
      - 5. Feels loss of control over everything.
      - 6. Lacks belief in future.
      - 7. Lacks vision of possible alternatives.
      - 8. Lacks belief that somehow the future could still be okay.
      - 9. Lacks belief in a transcendent purpose or being.
      - 10. Value of life placed on external things or individuals.
      - 11. Inability to experience love, caring, or trust in God, self and others.
      - 12. Lacks motivation to help self and often refuses help of others.
      - 13. Wishes for lack of existence and even death.
  5. Consider spiritual distress related to trust as a diagnostic label.
    - A. Relationship with God characterised by:
      - 1. Distance/separation/absence.
      - 2. Lack of belief.
      - 3. Uncertainty.
      - 4. Fear.
    - B. Lack of trust characterised by:

1. Lack of openness with God or a higher being.
  2. Lack of faith in a transcendent power.
  3. Fear of God's intentions.
  4. Inability to find solace in difficult times.
  5. Uncomfortableness with awareness of self.
  6. Gullibility.
  7. Either total reliance on self or overdependence on others little independence.
  8. Little faith in self.
  9. Feels need to be perfect before accepted by God and others.
  10. Feelings of alienation and loneliness.
  11. Inability to be open with others.
  12. Manipulative relationships with others.
  13. Feelings that only certain people and places are safe.
  14. Fears and avoids new situations and new people.
  15. Expects people to be unkind and undependable unless they demonstrate to the contrary.
  16. Wants prompt gratification, not being able to trust enough to wait.
  17. Is less accepting of others, especially those who deviate from his ways of thinking, feeling and behaving.
6. Consider spiritual distress related to meaning and purpose in life as a diagnostic label.
- A. Relationship with God characterised by:
1. Distance/separation/absence.
  2. Lack of belief.
  3. Uncertainty.
  4. Fear.
- B. Lack of meaning and purpose in life characterised by:
1. Lack of reason for living.
  2. Inability to find meaning in life's struggles.
  3. Inability to cope with life's struggles.
  4. Inability to know and thus act out one's true values.
  5. Lack of goals in life.
  6. Feelings of meaningless in life.
  7. Feelings of inner emptiness.
  8. Existential vacuum:
    - a. Addictions
    - b. Juvenile or adult delinquency.
    - c. Rampant sexual libido.
  9. A life goal of power.
    - A goal of power through money.
  10. A life goal of pleasure.
  11. Complaints of dissatisfaction with marriage, vocation and/or depression.
  12. Setting only one all-important goal to direct all activities.
  13. Trying to reach unattainable goals (for example perfection).
  14. Unclear values, beliefs, and goals.

15. Conflicting values.
16. Incongruence of life-style and true values.
17. Lack of commitment.
18. Conflict of beliefs with those of significant others.



SPIRITUAL DISTRESS AND WELL-BEING INDICATORS USED BY HIGHFIELD AND CASON (1983)

SIGNS OF SPIRITUAL PROBLEMS

1. NEED FOR MEANING AND PURPOSE IN LIFE.

- Expresses that he has no reason to live.
- Questions the meaning in suffering and death.
- Expresses despair.
- Exhibits emotional detachment from self and peers.
- Jokes about life after death.

2. NEED TO RECEIVE LOVE.

- Worries about how the rest of his family will manage after his death.
- Expresses feelings of a loss of faith in God.
- Expresses fear of dependence.
- Does not discuss feelings about dying with significant others.
- Does not call on others for help when he needs it.
- Expresses fear of tests and diagnosis.
- Expresses feeling lack of supportive others.
- Behaves as he "should" by conforming to the behaviour of a "good" patient or person.
- Refuses to co-operate with health care regimen.
- Expresses guilt feelings.
- Confesses thoughts and feelings about which he is ashamed.
- Expresses anger with self/others.
- Expresses ambivalent feelings toward God.
- Expresses despondency during illness/hospitalisation.
- Expresses resentment towards God.
- Expresses loss of self-value due to decreasing physical capacity.
- Expresses fear of God's anger.

3. NEED TO GIVE LOVE.

- Worries about financial status of family during hospitalisation/separation from family.
- Worries about separation from others through death.

4. NEED FOR HOPE AND CREATIVITY.

- Expresses fear of loss of control.
- Is unable to pursue creative outlets due to high level of physical disability.
- Expresses boredom during illness and hospitalisation.
- Exhibits overly dependent behaviours.
- Expresses anxiety about inability to pursue career, marriage and parenting because of illness.
- Expresses fear of therapy.
- Denies the reality of his condition.

## SIGNS OF SPIRITUAL HEALTH

### 1. NEED FOR MEANING AND PURPOSE IN LIFE.

- Expresses that he has lived in accordance with his value system in the past.
- Expresses desire to participate in religious rituals.
- Lives in accordance with his value system at present.
- Expresses contentment with his life.
- Expresses hope in the future.

### 2. NEED TO RECEIVE LOVE.

- Expresses hope in life after death.
- Expresses hope in the health care team.
- Expresses feelings of being loved by others/God.
- Expresses feelings of forgiveness by others/God.
- Expresses the desire to perform religious rituals leading to salvation.
- Trusts others/God with the outcome of a situation in which he feels he has no control.

### 3. NEED TO GIVE LOVE.

- Expresses love for others through actions.
- Seeks the good of others.

### 4. NEED FOR HOPE AND CREATIVITY.

- Asks for information about his condition realistically.
- Sets realistic personal health goals.
- Uses time during illness/hospitalisation constructively.
- Values his inner self more than his physical self.

APPENDIX 2

PILOT VERSION OF QUESTIONNAIRE AND COVER LETTER

# Queen Margaret College

EDINBURGH

Principal: Donald Leach, BSc, FIMA, CPhys, MInstP, MBCS

Clerwood Terrace · Edinburgh · EH12 8TS

Telephone : 031-339 8111

Fax No. : 031-339 6697

## DEPARTMENT OF HEALTH AND NURSING

Head of Department: Professor W W Thomson, BSc(SocSci)  
DipNAdmin RGN SCM ONC RNT

Date as post marked.

Dear Colleague,

### RESEARCH STUDY ON THE SPIRITUAL CARE OF PATIENTS

I am a nurse researcher about to undertake the above study, and am writing to invite you to participate in the pilot stage.

Because the group of nurses includes only staff nurses and charge nurses working full time on "care of the elderly" wards, your participation is extremely important.

As you may be aware, much has been written recently about total patient care which incorporates physical, social, psychological and spiritual aspects. My interest is in spiritual care.

Codes of Nursing state that nurses should:

- "Take account of the spiritual beliefs of patients/clients".  
(UKCC).
- "...promote an environment in which the values, customs and spiritual beliefs of the individual are respected."  
(ICN).

Despite the above, I have been unable to find any agreed definition of what the term "spiritual" actually means, or any explanation of what spiritual care should involve. The aim of this study is, therefore, to explore with nurses their views on this aspect of patient care. The study is of particular importance as it is hoped that the findings will contribute to the enhancement of the quality of life of hospitalised elderly patients.

It is with the above aim in mind that I am looking for help from experienced nurses like yourself. I am interested in your opinions on this aspect of patient care. Your participation is entirely voluntary, but I hope very much that you will be willing to help me.

I would be grateful if you could complete the enclosed questionnaire. As it is designed to obtain information about your own opinions and experience, please do not discuss it with any of your colleagues. All the information you give me will remain confidential, therefore please do not enter your name on any part of the questionnaire or envelope.

Because it is planned to conduct a follow-up study at some later date, in which you may be invited to participate, it is important that I can trace you again. For this reason there is a number at the top of your questionnaire. This corresponds to your name which is written on a list kept by me. No-one has access to this list and it is kept in a locked drawer. On completion of the study it will be destroyed. Your name will not be mentioned in any report or other document, and the information you give me will be used only for the purpose of this study.

Permission to conduct the study has been granted by the appropriate authorities within your Health Authority, from whom the list of names (from which you were selected) was obtained.

It is anticipated that the study will lead to a published report which will be of benefit to our profession. Should you have any questions at all concerning the study, please do not hesitate to contact me at the above address.

Thank you in advance, for all your time and effort , and I look forward to reading your completed form.

Yours sincerely,

Linda Waugh  
Nurse Researcher

Linda Waugh is enrolled full time as a research nurse in the Department of Health and Nursing at Queen Margaret College, Edinburgh. Any help you can give her with this study will be greatly appreciated.

*W W Thomson*

Professor W W Thomson  
Head of Department

RESEARCH STUDY ON THE SPIRITUAL CARE OF PATIENTS

1-2

4-6

PART A

As it may be that people with different experiences have varying opinions, it would be helpful to have your answers to the following questions. Please circle the appropriate response.

If you require more space or would like to make any comments, please use the back of the sheet, making sure that you number the question where appropriate.

1. Male/Female  
1 2

8

2. To which age group do you belong?

10

Under 21 yrs/ 21-29 yrs/ 30-39 yrs/ 40-49 yrs/ 50-59 yrs/  
60 yrs<sup>1</sup> and over.<sup>2</sup>  
6

3. How long have you been in actual practice since registering as a general nurse?

12

Less<sup>1</sup> than 1 yr/ 1-5 yrs/<sup>2</sup> 6-10 yrs/<sup>3</sup> 11-25 yrs/<sup>4</sup> 26 yrs and over.<sup>5</sup>

4. What type of ward are you working on at present?

14-15

Long term care/<sup>01</sup> Geriatric assessment/<sup>02</sup> Geriatric medicine/<sup>03</sup>  
Geriatric rehabilitation/<sup>04</sup> Other - please specify.<sup>05</sup>

---

06-

5. Which of the following duties do you normally work?

17-18

Day duty/<sup>01</sup> Night duty/<sup>02</sup> Rotation of day and night duty/<sup>03</sup> Other -  
please specify.<sup>04</sup>

---

06-

1

## PART B

Because of the confusion surrounding the meaning of the spiritual dimension and spiritual care, I would value your responses to the following questions. Please write your answers in the spaces provided. Again you may use the back of the sheet.

1 How would you define the term "spiritual need"? 20-21

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---

---

01-

2 How would you define the term "spiritual care"? 23-24

---

---

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01-

3 Who do you think should be responsible for responding to patients' spiritual needs? 26-27  
(Please tick one box only).

Nurse  
alone

Nurse in  
conjunction  
with clergy

Clergy  
alone

No-one

Other-  
please  
specify

☐

01

☐

02

☐

03

☐

04

☐

05

4.1 From your own experience, can you think of a patient who, in your opinion, had a spiritual need? 29  
(Please tick one box only).

YES

NO

☐

1

☐

2

If "No" please proceed to Q5 overleaf  
If "Yes", please continue



2

4.2 How did you recognise this need?

31-32

---

---

---

01-

4.3 What did you do in response to this need?

34-35

---

---

---

01-

4.4 How effective do you consider this response was?  
(Please tick one box only).

37

Totally  
effective

More  
effective  
than  
ineffective

Don't  
know

More  
ineffective  
than  
effective

Totally  
ineffective

☐

1

☐

2

☐

3

☐

4

☐

5

What makes you think that?

39-40

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---

---

01-

4.5 In retrospect, would you have responded any differently?  
(Please tick one box only).

42

YES

NO

☐

1

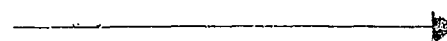
☐

2

If "No" please proceed to Q5 overleaf

If "Yes" please continue

↓  
3





4.6 What would you have done differently?

44-45

01-

As it is possible that connections may exist between religious affiliation and certain responses given, I would appreciate it if you would answer this question.

5 Do you have any religious affiliation?  
(Please tick one box only).

47

YES

NO

☐

1

☐

2

If "Yes", what is it?

01-

49  
- 50

How long did it take you to complete the questionnaire?

Thank you for taking the time to complete this questionnaire. Please return it to me, in the envelope provided, within the next 2 weeks if possible.

PART C

52-53

To be used only if you have chosen not to complete the questionnaire.

If you have chosen not to complete the questionnaire, would you mind sharing your reasons with me?

I have decided not to complete the questionnaire because:

APPENDIX 3

FINAL VERSION OF THE QUESTIONNAIRE AND COVER LETTER

# Queen Margaret College

EDINBURGH

Principal Donald Leach, BSc, FIMA, CPhys, MInstP, CEng, MBCS

Clerwood Terrace · Edinburgh · EH12 8TS



Telephone : 031-317 3000

Fax No. : 031-317 3256

**Health and Nursing**

Head of Department

Prof W W Thomson BSc (Soc Sci),  
RGN, SCM, ONC, DipNAdmin, RNT

Date as post marked.

Dear Colleague,

## RESEARCH STUDY ON THE SPIRITUAL CARE OF PATIENTS

I am a nurse researcher about to undertake the above study, and am writing to invite you to participate.

Because the group of nurses includes only staff nurses and charge nurses working full time on "care of the elderly" wards in Scotland, your participation is extremely important.

As you may be aware, much has been written recently about total patient care, which incorporates physical, social, psychological and spiritual aspects. My interest is in spiritual care.

Despite the fact that Codes of Nursing and nursing literature make reference to spiritual care, I have been unable to find any agreed definition of what the term "spiritual" actually means, or any explanation of what spiritual care should involve. The aim of this study is, therefore, to explore with nurses their views on this aspect of patient care. The study, the first of its kind to be undertaken in Scotland, is of particular importance as it is hoped that the findings will contribute to the enhancement of the quality of life of hospitalised elderly patients.

It is with the above aim in mind that I am looking for help from experienced nurses like yourself. I am interested in your opinions on this aspect of patient care. Your participation is entirely voluntary, but I hope very much that you will be willing to help me.

I would be grateful if you could complete the enclosed questionnaire, which should take you about 10 - 20 minutes. As it is designed to obtain information from your own opinions and experience, please do not discuss it with any of your colleagues. All the information you give me will remain confidential, therefore please do not enter your name on any part of the questionnaire or envelope.

Because it is planned to conduct a follow-up study at some later date, in which you may be invited to participate, it is important that I can trace you again. For this reason there is a number at the top of your questionnaire. This corresponds to your name which is written on a list kept by me. No-one has access to this list and it is kept in a locked drawer. On completion of the study it will be destroyed. Your name will not be mentioned in any report or other document, and the information you give me will be used only for the purpose of this study.

Permission to conduct this study has been granted by the appropriate authorities within your Health Board, from whom the list of names (from which you were selected) was obtained.

It is anticipated that the study will lead to a published report which will be of benefit to our profession. Should you have any questions at all concerning the study, please do not hesitate to contact me at the above address.

Thank you in advance, for all your time and effort , and I look forward to reading your completed form.

Yours sincerely,

Linda Waugh  
Nurse Researcher

Linda Waugh is enrolled full time as a research nurse in the Department of Health and Nursing at Queen Margaret College, Edinburgh. Any help you can give her with this study will be greatly appreciated.



Professor W W Thomson  
Head of Department

RESEARCH STUDY ON THE SPIRITUAL CARE OF PATIENTS

COL. COD

PART A

As it may be that people with different experiences have varying opinions, it would be helpful to have your answers to the following questions. Please circle the appropriate response.

1-2

If you require more space or would like to make any comments, please use the back of the sheet, making sure that you number the question where appropriate.

4

6

1 Male/Female

8

2 To which age group do you belong?

10

Under 21 yrs/ 21-29 yrs/ 30-39 yrs/ 40-49 yrs/ 50-59 yrs/  
60 yrs and over.

3 How long have you been in actual practice since registering as a general nurse?

12

Less than 1 yr/ 1-5 yrs/ 6-10 yrs/ 11-25 yrs/ 26 yrs and over.

4 What type of ward are you working on at present?

14-15

Long term care/ Geriatric assessment/ Geriatric medicine/  
Geriatric rehabilitation/ Other - please specify.

5 Which of the following duties do you normally work?

17-18

Day duty/ Night duty/ Rotation of day and night duty/ Other-  
please specify.

## PART B

Because of the confusion surrounding the meaning of the spiritual dimension and spiritual care, I would value your responses to the following questions. Please write your answers in the spaces provided. Again you may use the back of the sheet.

1 How would you define the term "spiritual need"?

20-21

---



---



---

2 How would you define the term "spiritual care"?

23-24

---



---



---

3 Who do you think should be responsible for responding to patients' spiritual needs?  
(Please tick one box only).

26-27

Nurse  
alone

Nurse in  
conjunction  
with clergy

Clergy  
alone

No-one

Other-  
please  
specify

☐
☐
☐
☐
☐

4.1 From your own experience, can you think of a patient who, in your opinion, had a spiritual need?  
(Please tick one box only).

29

YES

NO

☐
☐

If "No" please proceed to Q5 overleaf  
If "Yes", please continue



4.2 How did you recognise this need?

31-32

---

---

---

4.3 What did you do in response to this need?

34-35

---

---

---

4.4 How effective do you consider this response was?  
(Please tick one box only).

37

Totally  
effective

More  
effective  
than  
ineffective

Don't  
know

More  
ineffective  
than  
effective

Totally  
ineffective

☐☐☐☐☐

What makes you think that?

39-40

---

---

---

4.5 In retrospect, would you have responded any differently?  
(Please tick one box only).

42

YES

NO

☐☐

If "No" please proceed to Q5 overleaf  
If "Yes" please continue



4.6 What would you have done differently?

COL.	COD
44-45	

As it is possible that connections may exist between religious affiliation and certain responses given, I would appreciate it if you would answer this question.

5 Do you have any religious affiliation?  
(Please tick one box only).

47

YES

NO

☐☐

If "Yes", what is it? \_\_\_\_\_

49-50

Thank you for taking the time to complete this questionnaire. Please return it to me, in the envelope provided, within the next 2 weeks if possible.

PART C

To be used only if you have chosen not to complete the questionnaire.

52-53

If you have chosen not to complete the questionnaire, would you mind sharing your reasons with me?

I have decided not to complete the questionnaire because:

55-56



APPENDIX 4

COPIES OF LETTERS IN PREPARATION FOR THE QUANTITATIVE PART  
OF THE STUDY

# Queen Margaret College



EDINBURGH

Principal: Donald Leach, BSc, FIMA, CPhys, MInstP, MBCS

Clerwood Terrace · Edinburgh · EH12 8TS

Telephone : 031-339 8111

Fax No. : 031-339 6697

**DEPARTMENT OF HEALTH & NURSING**

Head of Department : Professor W. W. THOMSON, BSc (Soc Sc),  
RGN, SCM, ONC, Dip Nadmin

26 January 1990

Dear Sir/Madam,

I am a MPhil/PhD research student based in the Department of Health and Nursing at Queen Margaret College, Edinburgh and am hoping to be conducting research in your Health Board in the near future.

I am looking at the spiritual dimension of nursing care and am currently corresponding with the appropriate Ethics Committee in your area, with view to obtaining permission to interview/distribute questionnaires to nurses.

With this in mind, I would be grateful if you could provide me with the following information in relation to the hospitals listed over leaf:

1 the number of "long term" care of the elderly wards in each hospital

2 the number of care of the elderly "assessment" wards in each hospital

3 the number of Charge nurses and Staff nurses employed full time on the above wards in each hospital.

I realise that you may not be able to provide me with the information related to 3. If this is the case, would you mind either forwarding this letter to the person concerned or informing me as to whom I should contact? This would be very much appreciated.

Thankyou for your help and I look forward to hearing from you soon.

Yours faithfully,

Linda Waugh  
Research Student, Department of Health & Nursing

# Queen Margaret College

EDINBURGH

Principal: Donald Leach, BSc, FIMA, CPhys, MInstP, MBCS

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**DEPARTMENT OF HEALTH AND NURSING**

Head of Department: Professor W W Thomson, BSc(SocSc)  
DipNAdmin RGN SCM ONC RNT

29 January 1990

Dear

I am a MPhil/PhD research student currently registered with C.N.A.A. and based in the Department of Health and Nursing at Queen Margaret College, Edinburgh.

I am writing to you with the purpose in mind of gaining the approval of the Ethics Committee for your Health Board, concerning the implementation of the descriptive research study summarised overleaf.

I would be grateful if you could inform me as to:

- whether or not the enclosed summary of the study is suitable for submission to the Committee
- when the Committee is next likely to meet.

Thank you for giving this matter your consideration and I will be happy to supply you with any further information you may require.

I look forward to hearing from you soon.

Yours sincerely,

Linda Waugh  
Research Student

## SUMMARY OF PROPOSED RESEARCH STUDY

### INVESTIGATOR

Miss Linda Anne Waugh BA Nursing. (Commendation), RGN  
Department of Health & Nursing  
Queen Margaret College  
Edinburgh  
EH12 8TS

### SUPERVISION TEAM

#### Director of Studies:

Dr Lisbeth Hockey OBE, PhD, BSc, SRN, SCM, RNT, HV Cert, Dist.  
Nurse Cert, FRCN, Hon MD, Hon LLD, Hon FRCGP

Currently: Consultant in Nursing Research  
Guest Professor of Graz University, Austria  
Member of Queen Margaret College, Edinburgh

#### Supervisors:

1 Rev. Dr David Lyall, BSc, BD, STM, PhD

Currently: Lecturer in Practical Theology, Faculty of Divinity,  
St. Andrew's University

2 Miss Elaine Dove, MEd, BA Humanities, Teach.Cert, RGN, SCM,  
ONO, RNT, Post basic qualifications in  
neurological and neurosurgical nursing and  
spinal injuries rehabilitation nursing

Currently: Lecturer in the Department of Health and Nursing,  
Queen Margaret College, Edinburgh

### REFEREES

1 Professor R A K Schrock, MA, PhD, SRN, RMN, RNT

Currently: Head of Department of Nursing  
Zimmer F132, Neubau, Fachbereich Wirtschaft,  
Fachhochschule, Osnabruck,  
Albrechtstrasse 30, Germany (FRG)

2 Miss P Peattie, BSc (Soc,Sc), RGN, RSCN, RNT, Nurs.Cert.(Ed)

Currently: Principal of Lothian College of Nursing and Midwifery  
23 Chalmers Street  
Edinburgh EH9 3EW

#### TITLE

"Spiritual Care: What is it? How is it done?"

A descriptive study of staff nurses/charge nurses perceptions of spiritual care and stated responses to spiritual needs of patients in "care of the elderly" wards in Scotland.

#### PURPOSE

The research study is concerned with the spiritual dimension of nursing care, a subject which has not yet been widely investigated in Britain.

This area of care was initially explored and developed into a research proposal/dissertation for completion of a B.A.Nursing degree (Waugh,1986). From the literature reviewed, it became increasingly apparent that spiritual care could contribute greatly to patients' quality of life. It was, therefore, considered particularly relevant to care of the elderly, where hospital is often their home.

Before commencing the full time research currently being undertaken, exploratory interviews with ward sisters were conducted. These highlighted a number of points for further investigation.

It is hoped that this research will:

- shed further light on a vague and grossly neglected area of care, thereby adding to the existing but limited body of knowledge
- be used in nursing practice and education, thereby contributing to an increase in the quality of nursing care being offered to patients
- provide the impetus required to stimulate further research in this important area of care.

## AIMS

- 1 To explore with nurses their perceptions of terms such as:
  - "spiritual"
  - "spiritual need"
  - "spiritual care".
- 2 To describe what factors nurses use to enable them to identify spiritual needs.
- 3 To describe what intervention nurses consider appropriate in response to the identification of spiritual needs.
- 4 To describe which patient expressions nurses consider relevant to the spiritual dimension.

## POPULATION

It is intended to use charge nurses/staff nurses working full time, day or night duty, on care of the elderly wards in Scotland.

When the total population has been identified (names having been obtained from the appropriate contact person suggested by the Committee), a sample will then be selected for inclusion in the study. The exact sampling method has yet to be discussed with the statistician.

## METHOD

It is hoped to obtain the information relevant to the above aims by using a questionnaire and/or tape recorded interview.

If a questionnaire only is used, this will be mailed out to the entire population.

If a questionnaire and interview are used, the interview will be conducted and the questionnaire left with respondents to be returned by post (using the SAE provided) to the researcher.

The estimated interview time is 30 minutes. The results will then be analysed using the "SPSS" and/or "Ethnograph" packages.

The final approach has yet to be discussed with Dr.Hockey, who is presently out of the country.

If required, the final tools would be forwarded to you on request.

## SAFEGUARDING OF SUBJECTS

1 Subjects will be sent an outline of the study and their informed consent obtained prior to interview. The consent form will be sent out to them, together with the outline of the study, and a SAE enclosed for return of the former.

Subjects will then be contacted by telephone with a view to arranging a suitable time for interview.

If a questionnaire is being used, consent will be assumed by the completion and return of the questionnaire.

2 Because it will be necessary to contact subjects personally it will not be possible for them to remain anonymous, however their confidentiality will be maintained. This will be done by:

- asking them not to mention/write their own name or that of the hospital they are working in on the tape/questionnaire.
- ensuring that the list of subject names held by the researcher is either kept on her person (throughout the fieldwork) or in a locked drawer (at all other times).
- ensuring that only the researcher and the transcriber will listen to the tapes and that these are also kept in a locked drawer.
- ensuring that the tapes are destroyed on completion of the study.
- in the case of questionnaires, the code number on the questionnaire will correspond to the name of the subject, held by the researcher and known only to her.

## CLINICAL ACCESS

No part of the study will be initiated until permission to do so has been granted by the Committee. The policy guidelines for gaining clinical access will be followed.

Any further suggestions the Committee may have whereby the preservation of rights of subjects could be further improved, would be much appreciated.

## REFERENCE

Waugh, L A (1986). Spiritual care: the neglected dimension?  
Unpublished B A Nursing Dissertation. Queen Margaret College,  
Edinburgh.

### FURTHER INFORMATION

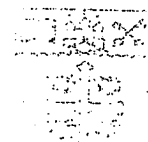
- 1 It is the intention to distribute postal questionnaires (around April/May 1990) to the staff nurses and charge nurses listed by the appropriate authorities within the Health Board.
- 2 Some of these nurses (approximately 4 per Health Board) would then be interviewed at around the same time next year.

### PROCESS FOR CONDUCTING THE STUDY

- 1 Contact Chief Area Nursing Officer.
- 2 Contact Directors of Nursing Services and/or anyone else as advised.
- 3 Write to Nursing Officers (or person as advised) of each hospital giving an explanation of the study and requesting the names of staff who meet with the stated criteria.
- 4 Post out questionnaires to Nursing Officers (or person as advised) to distribute to these nurses. (Each questionnaire will have the nurse's name on the envelope only).
- 5 Await return of completed questionnaires from the nurses. (An SAE will be included with the questionnaire).
- 6 If required, send a general reminder letter to Nursing Officers (or person as advised) to distribute to all nurses included in the study.



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**DEPARTMENT OF HEALTH AND NURSING**

Head of Department: Professor W W Thomson, BSc(SocSc)  
DipNAdmin RGN SCM ONC RNT

Dear

Thank you for your letter of 19 February 1990 confirming that my proposed research study need not be submitted to your Ethical Committee.

Provided that you are in agreement, I would very much like to proceed with the study using nurses from your Health Board. I would, therefore, like to distribute postal questionnaires (around April/May 1990) to a sample of nurses working in the following hospitals:

Some of these nurses (approximately 4 per Health Board) would then be interviewed at around the same time next year. When finalised, I will send you a copy of the cover letter, questionnaire and interview schedule.

In order to plan the study, I have been in contact with (Statistical Assistant) to obtain ward and staffing information with regard to the above listed hospitals. She was, however, unable to provide me with the latter. I wonder, therefore, if you could tell me the number of staff nurses and charge nurses who are working full time day and night duty in each of the above hospitals.

In case you would like more detail concerning the actual process involved in carrying out the study, this is outlined below. I would be grateful if you could advise me:

- on any changes that may be required at any of the stages
- as to whether or not I have your permission to go ahead with this.

# Queen Margaret College

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## DEPARTMENT OF HEALTH AND NURSING

Head of Department: Professor W W Thomson, BSc(SocSc)  
DipNAdmin RGN SCM ONC RNT

Should there be any further points requiring clarification, please do not hesitate to contact me.

Thank you for giving this matter your consideration and I look forward to hearing from you in the near future.

Yours sincerely,

Linda Waugh. Research Student.

### PROCESS FOR CONDUCTING THE STUDY

- 1 Contact Directors of Nursing Services and/or anyone else as advised.
- 2 Write to Nursing Officers of each hospital giving an explanation of the study and requesting the names of staff who meet with the stated criteria.
- 3 Select nurses, from the list, for inclusion in the study.
- 4 Post out questionnaires to Nursing Officers to distribute to the selected nurses. (Each questionnaire will have the nurse's name on the envelope only).
- 5 Await return of completed questionnaires from the nurses. (An SAE will be included with the questionnaire).
- 6 If required, send a general reminder letter to Nursing Officers to distribute to all nurses included in the study.

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**Health and Nursing**  
Head of Department  
Prof W W Thomson BSc (Soc Sci),  
RGN, SCM, ONC, DipNAdmin, RNT

6 April 1990

Dear

Thank you for your reply of 23 February 1990 in response to my letter dated 29 January 1990, concerning the implementation of my research study on spiritual aspects of patient care.

I hope that my letter, dated 27 February 1990, in which I sought to clarify a number of points previously raised by you, reached you.

I would be most grateful if you could advise me on what course of action I should now take or, if I did not adequately answer your questions, what further information you require. For this purpose, please find enclosed a prepaid envelope.

I look forward to your reply.

Yours sincerely,

Linda Waugh  
Research Student

# Queen Margaret College

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## DEPARTMENT OF HEALTH AND NURSING

Head of Department: Professor W W Thomson, BSc(SocSc)  
DipNAdmin RGN SCM ONC RNT

20 February 1990

Dear

Thank you for your letter of 16 February 1990 in response to my proposed research study. I hope that the following information answers your questions.

Concerning your first query, about the number of nurses for inclusion in the study, until I get the staffing information I requested from all the Health Boards in Scotland, I cannot predict this exactly. This information will determine whether I send a postal questionnaire to:

- 1 a sample of staff nurses and charge nurses working full time day and night duty on "care of the elderly" wards in the following hospitals:

or

- 2 all staff nurses and charge nurses, who meet the criteria in 1, working in the following hospitals ( i.e those classified as both general and geriatric)

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## DEPARTMENT OF HEALTH AND NURSING

Head of Department: Professor W W Thomson, BSc(SocSc)  
DipNAdmin RGN SCM ONC RNT

In relation to your second question, I plan to send out the questionnaires around April/May this year and would hope to interview a sample of these nurses, (estimated at about 4 per Health Board), at approximately the same time next year.

I have enclosed a draft copy of the cover letter and questionnaire as requested by you. As there may be some minor alterations in these, a final copy of each will be sent to you. Furthermore, when designed, the interview schedule for use in 1991 will also be forwarded to you.

In case you may require more detail concerning the actual process involved in carrying out the study, this is outlined as follows:

- 1 Obtain permission to conduct the study.
- 2 Contact Directors of Nursing Services and/or anyone else as advised.
- 3 Write to Nursing Officers of each hospital giving an explanation of the study and requesting the names of staff who meet with the stated criteria.
- 4 Select nurses, from the list, for inclusion in the study.
- 5 Post out questionnaires to Nursing Officers to distribute to the selected nurses. (Each questionnaire would have the nurse's name on the envelope only).
- 6 Await return of completed questionnaires from the nurses. (An SAE will be included with the questionnaire).
- 7 If required, send a general reminder letter to Nursing Officers to distribute to all nurses included in the study.

I hope the above adequately answers your questions. Should there be any further points requiring clarification, please do not hesitate to contact me.

Thank you for giving this matter your consideration and I look forward to hearing from you in the near future.

Yours sincerely,

Linda Waugh. Research Student.

# Queen Margaret College

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**DEPARTMENT OF HEALTH AND NURSING**

Head of Department: Professor W W Thomson, BSc(SocSc)  
DipNAdmin RGN SCM ONC RNT

27 February 1990

Dear

Thank you for your letter of 23 February 1990 in which you requested clarification of certain points in my proposed research study.

Firstly, I will not require access to patients or patient data for any part of the study. Rather, I will be using only nursing staff as outlined in the summary forwarded to you.

Secondly, should you require further details, I would like to distribute postal questionnaires (around April/May 1990) to a sample of nurses working in the following hospitals:

Some of these nurses (approximately 4 per Health Board) would then be interviewed at around the same time next year. (When finalised, a copy of the cover letter, questionnaire and interview schedule would be forwarded to you).

I have attached below an outline of the envisaged process for conducting the study. If your permission is obtained, I would appreciate any advice you would have to give me with regard to:

- any changes that may be required at any of the stages outlined
- whether or not I can go ahead with this outline.

# Queen Margaret College

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## DEPARTMENT OF HEALTH AND NURSING

Head of Department: Professor W W Thomson, BSc(SocSc)  
DipNAdmin RGN SCM ONC RNT

Should there be any further points requiring clarification, or any additional information you require, please do not hesitate to contact me.

Thank you for giving this matter your attention and I look forward to hearing from you in the near future.

Yours sincerely,

Linda Waugh Research Student

### PROCESS FOR CONDUCTING THE STUDY

- 1 Contact Directors of Nursing Services and/or anyone else as advised.
- 2 Write to Nursing Officers of each hospital giving an explanation of the study and requesting the names of staff who meet with the stated criteria.
- 3 Select nurses, from the list, for inclusion in the study.
- 4 Post out questionnaires to Nursing Officers to distribute to the selected nurses. (Each questionnaire will have the nurse's name on the envelope only).
- 5 Await return of completed questionnaires from the nurses. (An SAE will be included with the questionnaire).
- 6 If required, send a general reminder letter to Nursing Officers to distribute to all nurses included in the study.

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**Health and Nursing**  
Head of Department  
Prof W W Thomson BSc (Soc Sci),  
RGN, SCM, ONC, DipNAdmin, RNT

6 April 1990

Dear

You may recall that I wrote to you on 29 January 1990 concerning a research project I was hoping to gain permission to implement in your Health Board Area. This was concerned with spiritual aspects of patient care.

My supervisors and I are anxious to know your decision with regard to this matter and I have, therefore, included a prepaid envelope for this purpose.

Also, please find enclosed further details for conducting the study, which I hope meet with your approval.

Thank you in advance for your help and should you have any queries, please do not hesitate to contact me.

I look forward to your reply.

Yours sincerely,

Linda Waugh  
Research Student



# Queen Margaret College

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**Health and Nursing**  
Head of Department  
Prof W W Thomson BSc (Soc Sci),  
RGN, SCM, ONC, DipNAdmin, RNT

3 April 1990

Dear

I am a MPhil/PhD research student based at the above institution, and am writing to you as suggested by concerning a research study I am hoping to conduct in your Health Board Area in the near future.

Permission to conduct the study has been granted by the Ethical Committee for your Health Board and by has informed me that he has sent you a copy of information entitled "Summary of the Proposed Research Study" and "Further Information" which I had previously forwarded to him. I hope you won't mind the nurses in participating in the study.

I am writing to you in the hope that you will help me by providing me with the necessary information I require in order to proceed with the study. I require to know the names of all staff nurses and charge nurses working full time day and night duty on "care of the elderly" wards in Woodcot Hospital.

As you will see from the sheet entitled "Further Information", it is my intention to send the questionnaires to Nursing Officers to distribute to the nurses. I would very much appreciate it if you could confirm with me whether or not you are happy to be involved in this way. If so, then the study would proceed as outlined.

I have enclosed a prepaid envelope for the above purposes and a copy of the cover letter and questionnaire will be forwarded to you in due course.

I hope this has not inconvenienced you too much, and I appreciate your help.

Should you have any queries, please do not hesitate to contact me and I look forward to hearing from you in the near future.

Yours sincerely,

Linda Waugh  
Research Student

# Queen Margaret College

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**Health and Nursing**  
Head of Department  
Prof W W Thomson BSc (Soc Sci),  
RGN, SCM, ONC, DipNAdmin, RNT

3 April 1990

Dear

I am a MPhil/PhD research student based at the above institution, and am writing to you as suggested by

Permission has been obtained from \_\_\_\_\_ to conduct a research study in your Health Board Area, a summary of which is enclosed.

I am writing to you in the hope that you will help me either by providing me with the necessary information I require in order to proceed with the study or by informing me as to whom I should contact. I require to know the names of all staff nurses and charge nurses working full time day and night duty on "care of the elderly" wards in \_\_\_\_\_ Hospitals.

In addition I would be grateful if you could advise me as to whom I should send the questionnaires for distribution to the nurses. For the above purposes, please find enclosed a prepaid envelope.

A copy of the cover letter and questionnaire for distribution to the nurses would be forwarded to you in due course.

I hope this has not inconvenienced you too much, and I appreciate your help.

Should you have any queries, please do not hesitate to contact me and I look forward to hearing from you in the near future.

Yours sincerely,

Linda Waugh  
Research Student

# Queen Margaret College

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**Health and Nursing**  
Head of Department  
Prof W W Thomson BSc (Soc Sci),  
RGN, SCM, ONC, DipNAdmin, RNT

3 April 1990

Dear

Thank you for your letter of 23 March 1990 concerning my proposed research study on the spiritual care of patients.

I am writing to confirm that I will require to know the names of all staff nurses and charge nurses working full time day and night duty on both Assessment and Continuing Care of the elderly wards situated in Hospitals. I hope this answers your question.

Thank you for giving this matter your attention and should you have any further queries, please do not hesitate to contact me.

Yours sincerely,

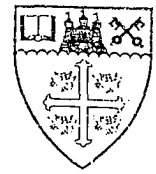
Linda Waugh  
Research Student

# Queen Margaret College

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**Health and Nursing**  
Head of Department  
Prof W W Thomson BSc (Soc Sci),  
RGN, SCM, ONC, DipNAdmin, RNT

10 April 1990

Dear

Thank you for your letter of 5 April 1990 concerning my research study on the spiritual dimension of nursing care and, although this will take some time to complete, I will be only too pleased to notify you of the study results.

I was uncertain as to whether or not I had sent you the sheet entitled "Further Information", therefore please find this enclosed. As you will see from this sheet, rather than asking staff if they would like to participate in the study, it was my intention to obtain from you, provided you are in agreement, the names of all staff nurses and charge nurses working full time day and night duty on "care of the elderly" wards situated in the Hospital, which I am assuming you have charge of. I have not included Hospital because it contains psychogeriatric wards, which automatically excludes it from the study.

Having obtained this list of staff names, I would then randomly select a sample of nurses for inclusion in the study, having informed them that their participation is entirely voluntary. If they do not wish to participate, then they simply do not complete the questionnaire.

It is important for the validity and reliability of the study, that as far as possible an unbiased sample is obtained, and therefore that the above outline is followed.

I hope that this meets with your approval and that you will be able to assist me by providing me with the information I require. Furthermore, as you will see from the enclosed sheet, it is my intention to send the questionnaires to Nursing Officers to distribute to staff. I would appreciate it, therefore, if you could inform me as to whom I should contact for this purpose.

Please find enclosed a prepaid envelope.

I would like to take this opportunity to thank you in advance for your assistance and should you have any queries, please do not hesitate to contact me.

I look forward to your reply.

With best wishes.

Yours sincerely,

Linda Waugh  
Research Student

# Queen Margaret College

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Health and Nursing

Head of Department

Prof W W Thomson BSc (Soc Sci),  
RGN, SCM, ONC, DipNAdmin, RNT

Date as post marked.

Dear Colleague,

## RESEARCH STUDY ON THE SPIRITUAL CARE OF PATIENTS.

By now, you will have received a questionnaire from me in relation to the above research study.

I would like to take this opportunity to thank those who have already returned their completed forms. The responses received have been most enlightening and helpful.

If you have not yet had time to complete the questionnaire, I would still very much like to hear from you. As no-one but you can give this information I hope that, even now, it will be possible for you to help me in this way.

I do hope to hear from you soon.

With best wishes.

Yours sincerely,

Linda Waugh.  
Nurse Researcher.

# Queen Margaret College

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**Health and Nursing**  
Head of Department  
Prof W W Thomson BSc (Soc Sci),  
RGN, SCM, ONC, DipNAdmin, RNT

Date as post marked.

Dear

## RESEARCH STUDY ON THE SPIRITUAL CARE OF PATIENTS.

Thank you for distributing the questionnaires related to the above research study. I have received many very interesting responses which are proving to be most helpful.

As outlined in the summary previously sent to you, if all questionnaires were not returned, it was my intention to send out a general reminder letter to all staff. I have, therefore, enclosed these and would be grateful if you could distribute them to the nurses concerned.

I very much appreciate your co-operation and would like to thank you once again for all your help.

Kind regards.

Yours sincerely,

Linda Waugh  
Research Student.



# Queen Margaret College

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Telephone : 031-317 3000  
Fax No. : 031-317 3256

Date as post marked.

Dear Colleague,

## RESEARCH STUDY ON THE SPIRITUAL CARE OF PATIENTS

It was found that, in the initial mailing for the above study, questionnaires failed to reach some nurses. As I have not heard from you I wonder if this is what happened in your case.

As you may be aware, much has been written about total patient care, which incorporates physical, social, psychological and spiritual aspects. My interest is in spiritual care. It is hoped that the information you give will lead to an increased understanding of what spiritual care involves and, in turn, contribute to the enhancement of the quality of life of hospitalised elderly patients.

Participation in the study is of course entirely voluntary, however, as no-one but you can give the information, your contribution is extremely important.

If you feel able to complete page 1 only, you may do so. I would appreciate it if you could return the questionnaire to me, using the prepaid envelope enclosed, within two weeks if possible.

In order to maintain confidentiality, this questionnaire has been posted to you direct.

Thank you in advance for your help and I look forward to reading your completed form.

Yours sincerely,

Linda Waugh  
Nurse Researcher

## APPENDIX 5

### ORIGINAL CATEGORIES FOR OPEN QUESTIONS

The percentages of responses classified under each category are stated in brackets.

CATEGORIES FOR QUESTIONS IN PART B OF THE QUESTIONNAIRE

Q1 HOW WOULD YOU DEFINE THE TERM 'SPIRITUAL NEED'?

<u>CATEGORY</u>	<u>%</u>
1 A need which is not or is more than: physical; mental; emotional; social.	1.3
2 A psychological or emotional need.	1.5
3 A deep inner need. A need of the 'soul' or core of the person.	3.1
4 Need to believe in something/someone. Includes:	34.1
a) The possession of a value/belief system.	2.1
b) The religious part of the individual (i.e where there is no mention of relationship with God but only of religious rituals). Includes:	31.3
- Need for/of religion/religious belief whether in a conventional or non-conventional sense. Examples of words respondents used were 'belief', 'religion', 'faith', 'belief in a faith'.	15.5
- Need for access to/contact with the clergy e.g minister, priest, rabbi, hospital chaplain or church elder, church visitors, other religious representatives.	2.3
- Need to practise religion/faith through: prayer; reading of Bible/prayer book; worship; attending ward/church services; communion; sacraments; baptism; confession; involvement in church activities; special diets; special requests at death; watching 'Songs of Praise'.	7.1
c) The need for belief in/relationship with (i.e to know, communicate with, be close to, have faith in, follow, have contact with) God (God/a god, Christ, Holy Spirit, Higher Being, something greater than self) through: faith; prayer; clergy; meditation, for the purpose of experiencing: reassurance; life; help; comfort; strength; direction; fullness of life; solace; support; worship; wholeness; love; purpose; peace; meaning; forgiveness.	0.3

<u>CATEGORY</u>	<u>%</u>
d) The need to practise customs according to one's own culture.	0.4
5 Need for love, unity and forgiveness.	7 . 2
Love - to be loved and to love. Includes the need for companionship and to be accepted, understood, cared for, wanted, respected.	
Unity - to feel at one with self, others, God, surroundings, universe. The need to belong.	
Forgiveness - to be forgiven and to forgive. The need for reconciliation and security.	
Need for peace (includes contentment, happiness) with self, God, others, world in general.	
6 Need for sense of elation/joy/exuberance/more of life.	0.2
7 Need to achieve a state of comfort. Includes the need:	15.4
a) to be free from suffering, pain, anxiety or to be able to cope with these by:	
- being comforted	
- talking about it	
- receiving strength, support, reassurance, guidance from people, belief, religion	
b) to achieve an overall state of well-being/sense of wholeness	
8 Need for hope:	3.2
- in general	
- in life after death.	
9 An individual need which varies from person to person.	4.7
10 Need to find meaning in life.	4.0
11 Need to be alone/for reflection.	1.2
12 Need which appears in crisis and, in particular, on approaching death. Includes need:	9.0
- for acceptance of situation/death	
- to put 'affairs in order'	
- to be prepared for death.	

<u>CATEGORY</u>	<u>%</u>
13 Need for a sense of fulfilment/satisfaction.	4.4
14 Need to talk about/explore issues. Includes discussion of: beliefs, faith, life, death, afterlife, God, thoughts, feelings, emotions, desires.	6.8
15 Expressed difficulty in defining spiritual need	3 . 9

Q2.AND 4.3

HOW WOULD YOU DEFINE THE TERM 'SPIRITUAL CARE'?  
WHAT DID YOU DO IN RESPONSE TO THIS NEED?

<u>CATEGORY</u>	<u>%</u>
1 Recognising/respecting/meeting patients' spiritual needs. This category consisted of two sections.	12.4
a) More general statements (mainly from Q2) where spiritual care was considered to involve:	5.7
- recognising/being sensitive to the spiritual/religious needs of the individual	
- respecting the beliefs/religious beliefs of the individual	
- caring for/nurturing/maintaining the spirit/soul/beliefs/faith of the individual.	
b) More specific statements where spiritual care was considered to involve enabling patients to meet their spiritual needs. This 'enabling' took the form of:	6.7
- <u>allowing</u> the need to be met. Terms used included "allowing", "giving access", "letting" the patient do something in order to meet the need e.g pray, attend religious services, practise religion/beliefs, have contact with people such as clergy, have access to religious literature.	1.4
- <u>encouraging</u> the meeting of the need. This mainly included encouraging the continuation of religion while in hospital. Terms used included "making use of", "encouraging", "offering the opportunity", "making patients/relatives aware of" things like attendance at services, visits from clergy, contact with church, listening to religious programmes on the TV or radio.	0.8
- <u>doing</u> something to help the patient meet their need:	4.5
- generally responding/helping the patient in some way to meet their spiritual needs/practise their religion.	
- providing the patient with someone (e.g chaplain, home help so that could go home) or something (e.g special diet, Bible/talking Bible/prayer books/other literature, religious items such as rosary beads, phonic aid so that they could listen to services, attend services, experience an environment conducive to performance of rituals such as prayer, worship, dietary regulations, which would enable their need to be met.	

CATEGORY

%

- performing an act for/with the patient e.g dressing the body in a particular manner after death, administering milk at time of death, looking up and reading Bible passages to patient, praying with/for patient, opening window for a dying Jewish patient prior to death.
- ensuring that those patients with no beliefs were not forced to participate in inappropriate activities.
- 2 Communicating with patients/relatives by: 5.6
  - providing the opportunity/encouraging patients/relatives to express themselves freely. Included discussing/exploring various issues with them such as:- life, death, life after death, meaning of life
    - feelings, opinions
    - beliefs
    - needs, doubts, fears, anxieties.
  - listening
  - counselling
  - guiding e.g answering questions, giving advice.
- 3 Caring for and supporting the patient/family. 4.3
  - Caring by showing: interest, concern, kindness, love, understanding, sympathy, compassion.
  - Supporting by giving: comfort, reassurance, personal help, security, encouragement.
- 4 Promoting a sense of well-being (physical, mental, emotional, spiritual) by: 1.6
  - promoting healing (of body and mind)
  - relieving pain (physical by medication)
  - helping to alleviate worries, anxiety, fear, stress
  - helping patient achieve state of peace, comfort, contentment.

Giving more than physical care:

  - caring for the soul/spirit
  - caring for the whole person (body, mind, spirit)
  - giving individualised care.
- 5 Expressed difficulty in defining or giving spiritual care. 0.6

<u>CATEGORY</u>	<u>%</u>
6 *Referring to others. Referral took two forms: (Referral can also mean that the nurse felt that someone other than herself was responsible for giving spiritual care.)	51.6
a) Complete i.e nurse does not play an active part:	
- spiritual care is the care given by someone else, mainly the clergy but it may also include someone else with an understanding of the need.	3.1
- involves contacting the clergy	39.5
- contacting some source of help other than/in addition to the clergy i.e someone better qualified, outside agency, counsellor, lawyer, GP, Macmillan nurse, ward sister, person in charge of unit, doctor, OT, day staff, ex- member of staff who knew the patient well.	4.8
b) Partial i.e nurse plays an active part:	4.2
- nurse working together with the clergy/family.	
7 Doing nothing. Respecting patient's wishes for no action to be taken.	0.5
8 Helping the patient generally by:	6.4
- carrying out requests/wishes	
- meeting general needs.	
9 Giving/sharing of self.	2.6
- empathy	
- entering into patient's experience/sharing own experiences	
- establishing rapport/relationship with the patient.	
10 Being there. Includes:	10.1
- spending time	
- use of touch i.e holding hands, hugging.	
11 Giving the patient self esteem. Includes:	1.1
- making patient feel special	
- treating patient as a person	
- making patient feel worthwhile	
- being honest.	
12 Finding out more about patients' beliefs e.g by reading up on subject.	0.5
13 Documenting 'Nursing Process' records.	0.2
14 Using humour.	0.2



<u>CATEGORY</u>	<u>%</u>
15 Distracting the patient from the present situation. Trying to shift patient's attention from present situation to a more appealing one.	0.8
16 Supporting the patient. Helping patient to cope with/come to terms with situation e.g to find meaning.	1.5

#### Q4.2 HOW DID YOU RECOGNISE THIS NEED?

##### CATEGORY

%

##### 1 Through communication:

31.4

##### a) Patient expressed the need in some way

##### b) Verbal:

- patient/family/friends voiced need directly e.g asked for help, asked for clergy, rituals, religious items.
- patient/family/friends talked about: church, euthanasia, beliefs/faith or lack of them, loss of hope in being cured, illness, future, God, dying, death, past life, life after death, soul, feelings.
- way patient spoke.
- comments patient made.
- questions patient asked e.g about suffering, pain, God, heaven, after-life.

##### c) Non-verbal:

- facial expression, eyes.
- hand movements.
- general body language.

##### 2 Through observation of the patient. Includes:

13.2

##### a) observation of behaviour:

- practise of religious acts e.g reading Bible, praying, singing hymns, attending services.
- positive response e.g displayed happiness, peace, joy, elation to some form of spiritual stimulation such as visit from clergy, hearing religious music.

##### b) assessment:

- general e.g of patient's mood.
- on admission
- nurse sensed the need. Words used included: 'sensed', a 'feeling', 'reading between the lines', 'intuition', 'unnatural silence'.

##### 3 By knowing the patient:

9.3

##### a) as a person

##### b) knowing something about the patient:

- that they had strong beliefs
- their religious affiliation
- their occupation e.g nun, minister, lay preacher.

CATEGORY

%

- c) Through situation patient was in:  
- patient's poor condition/terminal illness  
- had suffered bereavement.
- 4 Distress displayed by the patient. Included: 22.5  
a) States like:  
- fear with regard to: - pain  
- apprehension - events going on  
- preoccupation - living  
- distress - death  
- anxiety - dying  
- after-life  
- future  
- unknown  
- sin  
- being alone
- b) Emotional states like:  
- 'agitated', 'emotional', 'upset'. Included crying.
- 5 Patient was awkward/hostile. Words used to 1.4  
describe this state included:  
'angry', 'antagonistic', 'bitter', 'aggressive'  
'demanding', 'attention seeking', 'refused to co-  
operate'.
- 6 Helplessness. Patient seemed: 8.7  
- to have lost hope/to have given up  
- depressed  
- withdrawn  
- despondent  
- disinterested  
- expressionless  
- apathetic  
- to desire death  
- to lack motivation.
- Patient felt lonely/alone:  
- patient did not want to be alone  
- patient felt alienated from church, God,  
husband.
- 7 Low self esteem. Included feelings of: 0 . 8  
- unworthiness  
- vulnerability.
- 8 Expressed desire/inability to come to terms with 9.9  
past/present/future. Included expression of:  
- regret

CATEGORY

%

- guilt - at not being faithful to his/her faith
  - asking for forgiveness
  - seeking reconciliation
- denial
- feelings of inability to cope
- search for meaning e.g 'why me?'
- need for reassurance.

9 Physical signs:

1.4

- pain
- elevated BP, pulse
- inability of physical interventions e.g drugs to alleviate problem.

10 Desire for life.

0 . 6

11 Prepared for death.

0.8



CATEGORY%

- verbal expression e.g words of thanks
  - non-verbal expression e.g smile, touch, eyes, gestures, facial expression.
- 6 Increased self esteem. Indicated by patient: 0.6
- viewing him/herself more positively
  - dying with dignity.
- 7 Need had been met. This was the assumption made by the nurse: 9.9
- when he/she had made an effort to meet the need
  - when interventions that the nurse had requested had been carried out e.g minister had visited
  - if it appeared that the need had been met e.g if patient: had been able to practice religion; did not mention problem again; seemed satisfied
  - when 'sensed it'.
- 8 Need was not met/not completely met. 6.0
- Need was not met. Included situations where:
- e.g minister did not come as promised.
  - patient's condition remained unchanged e.g patient remained sad, helpless, afraid, distressed, bitter, worried.
  - action was taken too late to meet the need.
- Need was not completely met. Included situations where:
- patient expressed dissatisfaction
  - patient was unable to practice religion fully
  - not enough time was spent with the patient.
- 9 Nurse felt inadequate in dealing with the situation. 1.9
- 10 Nurse did not know/found it difficult to assess the effectiveness of his/her response because: 9.7
- of patient's condition e.g unable to communicate, had died, had been transferred, was semi-conscious, was confused, was deaf.
  - patient did not give any feedback and/or nurse did not ask.
  - generally found it a difficult area to evaluate.

Q4.6 WHAT WOULD YOU HAVE DONE DIFFERENTLY?

<u>CATEGORY</u>	<u>%</u>
1 Acted earlier: - trusted own judgement earlier - given spiritual needs priority earlier.	6.7
2 Spent more time with patient/family - talking, listening, sharing - giving nursing care - 'being with' patient/family - building up trust.	26.7
3 Involved others: - sought advice on how to deal with situation/ discussed matter with other team members - family/friends/others - encouraged other staff involvement - spiritual care giver. - pressed more firmly for support from clergy.	48.9
4 Included spiritual care in the Nursing Process: a) Directly - documenting care plans and discussion at 'report'.	8.9
b) Indirectly - being more observant - enquiring about normal practices.	
5 Prayed with patient.	6 . 6
6 Tried to overcome own feelings of inadequacy.	2 . 2

CATEGORIES FOR QUESTION LOCATED IN PART C OF THE QUESTIONNAIRE

QC REASONS FOR NOT COMPLETING QUESTIONNAIRE

<u>CATEGORY</u>	<u>%</u>
1 Very private and personal thing.	18.2
2 Did not feel able to participate.	18.2
3 Spiritual care should be left to the chaplain.	13.7
4 No time.	4.5
5 Would have preferred to have been invited to respond.	4.5
6 Did not feel qualified to give spiritual care.	18.2
7 Found questions difficult to answer.	9.2
8 Working with the confused elderly who are unable to express spiritual needs.	4.5
9 Have not encountered anyone with a spiritual need.	4.5
10 Subject cannot be generalised.	4.5



APPENDIX 6

INTERVIEW SCHEDULE WITH ACCOMPANYING LETTERS

## INTERVIEW SCHEDULE

### PRELIMINARY DISCUSSION

- 1 Thank you for taking part in the study.
- 2 What time should we be finished by?
- 3 What do you think of the study?
- 4 What did you think of the questionnaire?
- 5 Did you have any difficulties in filling in the questionnaire?
- 6 Can you think of any ways in which the questionnaire could have been improved?
- 7 Do you have any other comments you would like to make or questions you would like to ask?
- 8 Explanation - I'd like to ask you a few questions based on the answers you've given in the questionnaire.

### SPIRITUAL NEED

- 1 Do you think that you can have spiritual needs that are not God related?  
  
If 'yes' what might they be?  
Can you give me some examples?
- 2 Do you think an atheist can have spiritual needs?  
  
If 'yes' what spiritual needs might they have?  
Can you give me some examples?
- 3 Do you think there's any difference between a psychological need and a spiritual need?  
  
If 'yes' what is the difference?
- 4 Specific questions relating to their definition of spiritual need.

### SPIRITUAL CARE.

- 1 Has a patient ever asked you to pray with them or read the Bible to them?
- 2 Would/did you feel comfortable doing this?
- 3 Do you think that any nurse can do this?

- 4 How would you feel about praying with a patient who belonged to another religion e.g muslim, hindu?
- 5 How would you feel about reading from another religious text e.g the Koran?
- 6 What factors in the ward environment might complicate the giving of spiritual care?
- 7 What factors in the ward environment might facilitate the giving of spiritual care?
- 8 Do you think that all nurses can give spiritual care?
- 9 Do you think that all nurses should be able to give spiritual care?
- 10 Specific questions relating to their definition of spiritual care and how they reported to have given it.

#### ROLE OF THE CLERGY IN SPIRITUAL CARE.

- 1 Have you ever contacted the clergy on behalf of a patient or relative?
- 2 At what point would you contact the clergy? i.e where does your role stop and that of the clergy start?
- 3 What would the clergy have to offer that you yourself feel you would be unable to offer?
- 4 What sorts of things would you feel happy about dealing with yourself?
- 5 Would you involve the clergy only if the patient requested it?
- 6 Are there any instances where you would contact the clergy without the patient specifically requesting it?
- 7 What is the relationship like between the nursing staff and the clergy on your ward?
- 8 If you were in charge and you had contacted the clergy, would he:
  - come and talk to you before going to see the patient?
  - go and see the patient himself or would a nurse go with him?
  - come and talk to you afterwards?
- 9 Would any of the above be noted in the patient's care plan or nursing kardex?
- 10 Would you say that the clergy is considered to be part of the health care team?

- 11 Does the clergy attend any ward meetings/patient profile discussions?

#### EVALUATING EFFECTIVENESS

- 1 What is effective spiritual care?
- 2 We've established that this patient's spiritual need was...  
You've indicated that you felt your intervention was...  
  
Can you tell me what led you to that conclusion?  
What had changed?

#### BELIEF SYSTEM

- 1 Do you mind if I ask you a few questions about your own personal beliefs?
- 2 You've indicated that you are \_\_\_\_\_ (state religious affiliation).
- 3 Which church do you go to?
- 4 Do you believe that the Bible is:  
a) the very words of God?  
b) a human document containing religious truths?
- 4 What is your opinion about the Billy Graham campaign?

#### TRAINING

- 1 When did you do your training?
- 2 Where did you do your training?
- 3 Did you receive any teaching on spiritual care in your training?  
  
If so, what form did it take?
- 4 Have you attended any refresher courses since your training which have included anything on spiritual care?
- 5 Do you think that teaching on spiritual care would be of help to you?

#### ADDITIONAL QUESTIONS

- 1 I've found that Sisters and Charge Nurses are more likely to identify spiritual needs than Staff Nurses which I thought may be because Sisters and Charge Nurses have usually been in practice longer. But I found no connection between

length of experience and identification of spiritual needs. Can you think of any reasons why Sisters and Charge Nurses would be more likely to identify spiritual needs?

- 2 You're working on \_\_\_\_\_ type of ward at present. Have you worked on any other type of ward?
- 3 Would you say that spiritual needs are just as likely to be identified on \_\_\_\_\_ ward as they are on \_\_\_\_\_ ward?
- 4 I've found that nurses working on long term care wards only or geriatric assessment wards only are less likely to identify spiritual needs than those who are working on varied wards e.g long term care + assessment, long term care + surgical.

Why do you think this might be?

#### CONCLUSION

- 1 Thank you.
- 2 Are there any other comments you'd like to make or questions you'd like to make?
- 3 Should I have any other questions would you be happy for me to phone you?
- 4 Explain about publications and sending summary of results in approximately a year's time.

10 June 1991

Dear Sister \_\_\_\_\_,

RESEARCH STUDY ON THE SPIRITUAL CARE OF PATIENTS

Thank you for returning your completed questionnaire to me. I found your comments extremely interesting, so much so that I would very much like to talk with you further.

If you agree, this would take the form of an informal chat lasting approximately 30 minutes - 1 hour. To help me pay full attention to what you say, I would like to tape record our talk. Your name would not be mentioned on the tape or in any written report. Only a typist and I would have access to the tape which, when not in use, would be kept locked.

In order to keep the confidentiality of our contact, it would be best if we could meet in the privacy of your home or in another place that suits you.

I hope very much that you will feel able to help me in this way and would very much appreciate it if you could complete the attached sheet and return it to me within the next 7 days. A pre-paid envelope is enclosed.

I look forward to hearing from you.

With best wishes.

Yours sincerely,

Linda Waugh  
Nurse Researcher.

I would be happy for you to phone me to make arrangements for us to meet for an informal discussion.

Signature: \_\_\_\_\_

I would not like you to phone me because:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

If you have agreed to be contacted please provide the following information using block capitals.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NO: \_\_\_\_\_

BEST TIME FOR TELEPHONING: \_\_\_\_\_

14 June 1991

Dear Sister \_\_\_\_\_,

RESEARCH STUDY ON THE SPIRITUAL CARE OF PATIENTS

I wrote to you recently, first of all to thank you for returning your questionnaire and, secondly to ask you if it would be possible for us to meet to have an informal chat as I found your comments so interesting.

In case my first letter failed to reach you I thought it best to write to you again to let you know that I would still very much like to talk with you. I realise that you are very busy but if you can spare some time this would be very much appreciated, especially as I have only selected 10 nurses in total for further discussion.

I hope that you will feel able to help me in this way and would be extremely grateful if you could complete and return the attached form to me at your earliest convenience, using the pre-paid envelope provided.

I look forward to hearing from you.

With best wishes.

Yours sincerely,

Linda Waugh  
Nurse Researcher.



I would be happy for you to phone me to make arrangements for us to meet for an informal discussion.

Signature: \_\_\_\_\_

I would not like you to phone me because:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

If you have agreed to be contacted please provide the following information using block capitals.

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

TELEPHONE NO: \_\_\_\_\_

BEST TIME FOR TELEPHONING: \_\_\_\_\_

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